R.N.

a journal for nurses

- American Hospital in Paris
- First Baby After 40
- Narcotic Problem Among Nurses

November 1955

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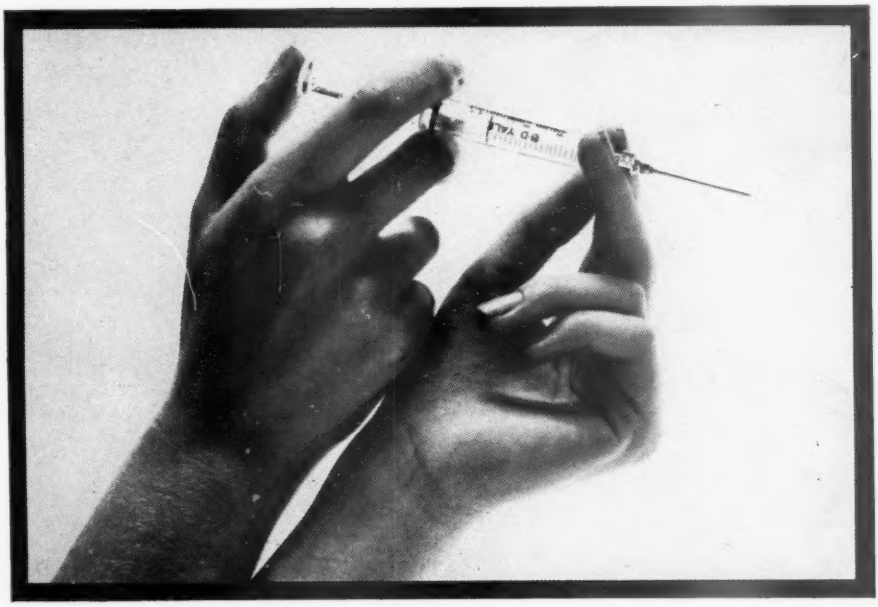
... made especially for you!



Pacquins Hand Cream for extra-dry skin is lanolin-rich. Pacquins gives more hands protection than any other hand cream in the world. Never sticky or greasy; vanishes quickly.

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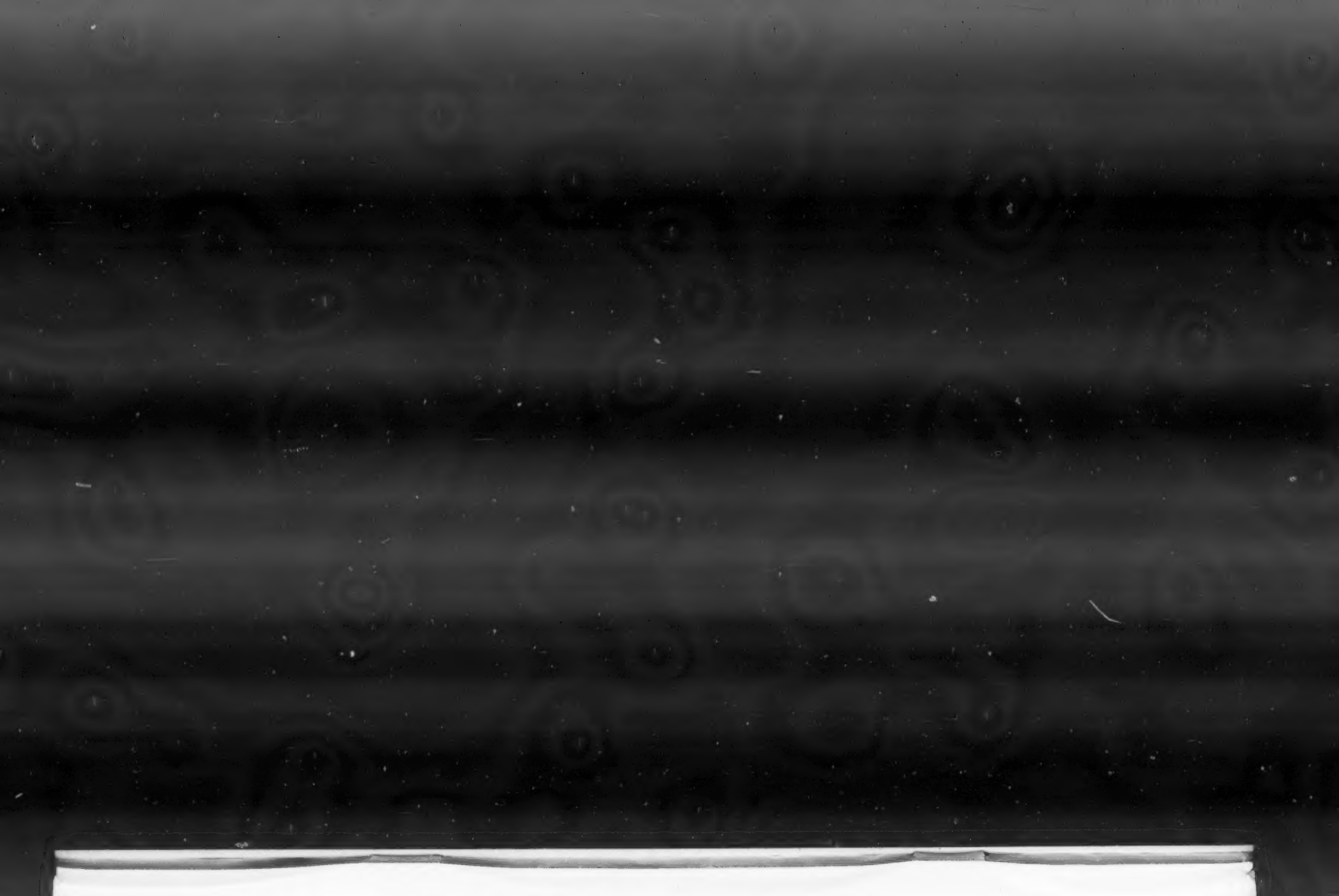

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R.N.

contents

NOVEMBER, 1955

VOL. 18, NO. 11

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Will it happen to you? Will you work, save and pinch pennies for next spring's outfit or next summer's vacation — only to have a sudden sickness or injury swallow up your money? *Why take the chance* when Commercial Travelers of Utica is now making available protection designed to give nurses the personal security they need today — at rates 25% to 33% *less* than the cost of similar policies offered by other leading companies.

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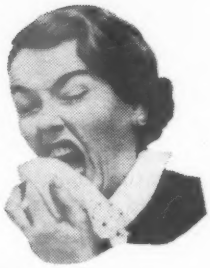
WHEN A PATIENT ASKS:

"Nurse, What Should I Take for my Cough?"



RECOMMEND THIS NEW, FAST, "2-WAY" RELIEF...

SUPER ANAHIST® Cough Syrup

The *only* cough syrup with Vitamin C!

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
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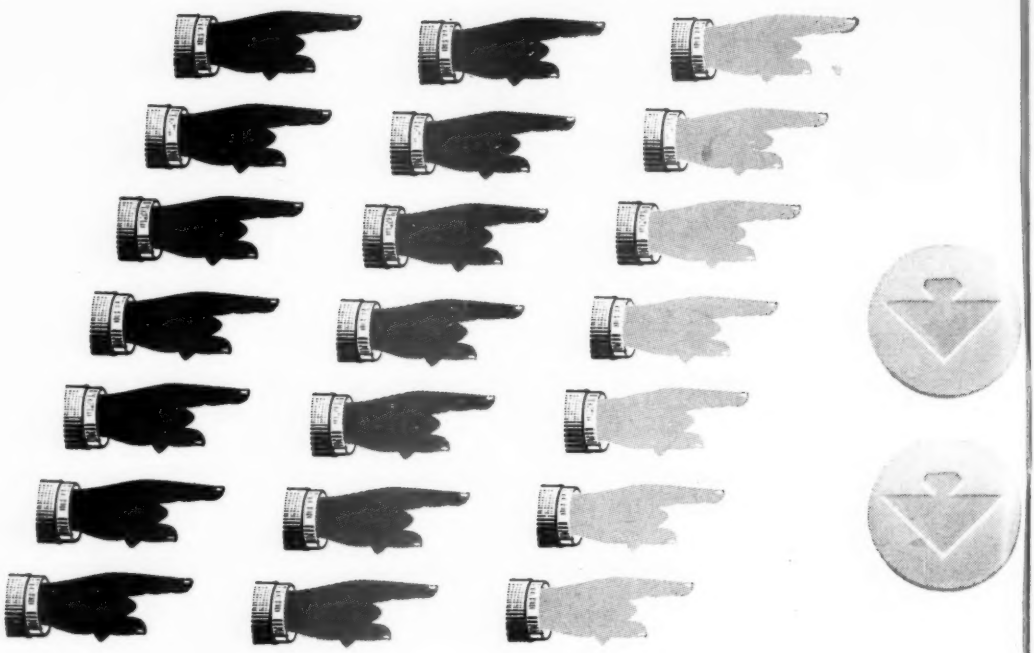

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Debits and Credits

He Had It Fine

Dear Editor:

Enclosed is a dollar to cover my subscription to your fine magazine. I'm resuming practice as a male nurse after serving two years in the Medical Corps. I must say the Army treated me fairly well. After five months of basic, I escaped infantry by getting into the Medical Corps. It took a lot of fight to do this, for some strange reason; but after I got in, I had it fine—six months on an NP section, three on a surgical ward, nine on postoperative recovery. As a result of the recovery-ward experience, I've taken up anesthesia.

Congratulations on your "Surgical Symposium" issue of last May.

R.N., YANKTON, S. D.

[*Men nurses are now eligible for commissions in the Army Nurse Corps.* *See page* 70.—THE EDITORS]

Mail-Bag Line

Dear Editor:

Several days ago, I chanced upon a hospital patient's "letter of thanks" in the "Mail Bag" column of our evening paper. The writer expressed her appreciation to all staff doctors and nurses who had attended her. One line caught my eye: "One of the nurses didn't have to take the time to care for me as she is a graduate, but did so from her heart."

Your August editorial expresses perfectly the fact that we are running far afield from true bedside nursing; and when patients begin to accept this fact, we definitely need to take action.

I read R.N. from cover to cover and thoroughly digest it. Each month I find some article or letter which intrigues me, and I tell myself that I'll write to you either in approval or rebuttal; but this is the first time I've actually done so.

GEORGIA MYERS SMITH, R.N.
ERLTON, N.J.

Quick Response

Dear Editor:

Your September article, "A Retirement Home in the Making," has already [Sept. 21] brought inquiries and requests for application blanks from nurses in New Jersey, California, Wisconsin, Louisiana, Oklahoma, North Carolina, New York, Arizona, and Texas.

Typical of the comments is this one from a 55-year-old public health nurse in Bay City, Tex., who is rounding out thirty years of service: "I expect to be active for many years yet, but it would give me a deep sense of peace to know I have a place to retire to, and San Antonio is the ideal spot. So please send me more particulars."

Most of the inquiries have come

from industrial nurses—which would seem to indicate that this field of practice makes nurses especially "security conscious." But there also seems to be plenty of interest in the project among private duty nurses, public health nurses, school nurses, office nurses, and nursing instructors. And we have heard from both the retired and semi-retired groups, as well as from many in full-time practice.

Kindly accept my sincere thanks for printing the story of what we are trying to do to make this retirement home a reality.

(Mrs.) Flora A. Murray, R.N.
President, Nurses' Reserve & Research Institute
San Antonio, Tex.

Teaching Parents-To-Be

Dear Editor:

I work for three doctors, two of them obstetricians. Our township VNA sponsors classes for expectant parents. I have shared in the planning of these classes and have thoroughly enjoyed teaching several sessions. One of my M.D.-employers conducts a popular "Future Fathers' Night." Our community is relatively small, but through cooperative efforts we have interested folks from as far away as 25 miles; and not only have we given these parents-to-be helpful information but we ourselves have learned a lot about our community and its resources.

I hope that with the organization of a Special Groups Section in the ANA will come the acceptance of the

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... may we have your support for

office nurse as a patient-educator. There were 35,000 of us in 1954; certainly, by organization, the setting of standards, and the exchange of ideas, the office nurse can be recognized as the important member of the community health team she is.

ELIZABETH L. ROBERTS, R.N.
MOORESTOWN, N.J.

Shocked

Dear Editor:

Returning to the States after serving as matron of a hospital in Costa Rica for five years, I find myself shocked by the great amount of waste in our hospitals—waste of supplies, foodstuffs, and equipment. My heart aches when I recall the undernourished state of my Costa Rican patients—babies with no fatty tissue, only skin over their bones; babies admitted for one ailment who were found to need therapy for three to five other conditions. And when I see materials wasted, I vividly recall the way my Costa Rican employes used to salvage every paper carton and packing box.

I have also been surprised by the marked lowering of our nursing standards. The present slogan appears to be, "Complete the assignment by the quickest possible method—regardless of the patient's welfare." We seem to be overlooking the need to make the patient comfortable. I wonder if the practical nurse will take over this need. If she does, it will be because of the constant emphasis on freeing students from bed-

Cold Weather *and* PSORIASIS

When winter comes there is a sharp rise in the incidence and severity of psoriasis. Ormsby and Montgomery[1] state: "In winter and in cold countries psoriasis is much more prevalent than in warmer seasons and climates."

A clinical investigation[2] of resistant psoriasis in which RIASOL was the only medication used showed a decided downward trend under treatment. There was definite improvement in 76% of all cases with complete disappearance of the skin patches in 38% of the total. The average period for clearing of the skin was less than 8 weeks.

By way of comparison, another clinical investigation[3] in which various medications other than RIASOL were used showed remissions in only 16½% of the cases.

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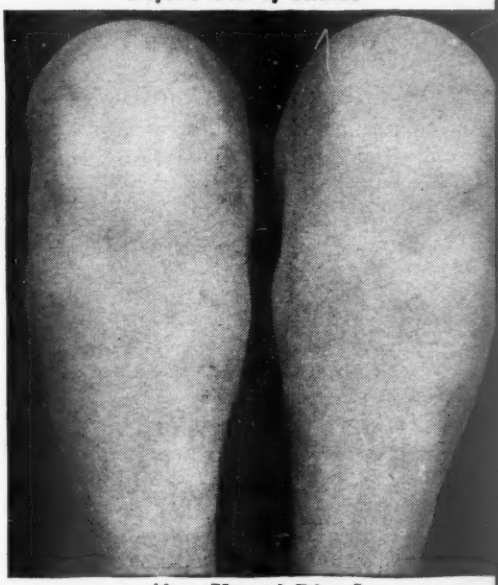
Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

1. *Diseases of the Skin*, 6th ed., 1943, p. 280.
2. *M. Rec.* 151:397, 1940.
3. *Arch. Dermat. & Syph.* 35:1051, 1937.

Before Use of Riasol



After Use of Riasol

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Not sent without Reg. No.

R.N. 11-55

Please send me professional literature and generous clinical package of RIASOL.

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City ..... Zone .... State .....

RIASOL FOR PSORIASIS

side care for supervisory work. One wonders who they are going to supervise. As one whose first love has ever been the patient, I feel a sense of great (but surely not irreparable) loss.

I am keenly interested in each new issue of your lively magazine (I was one of your "charter members"), and I urge you to continue the fight to restore our former high standards for the professional bedside nurse.

ETHEL LAWYER SHAW, R.N.
CANTON, OHIO

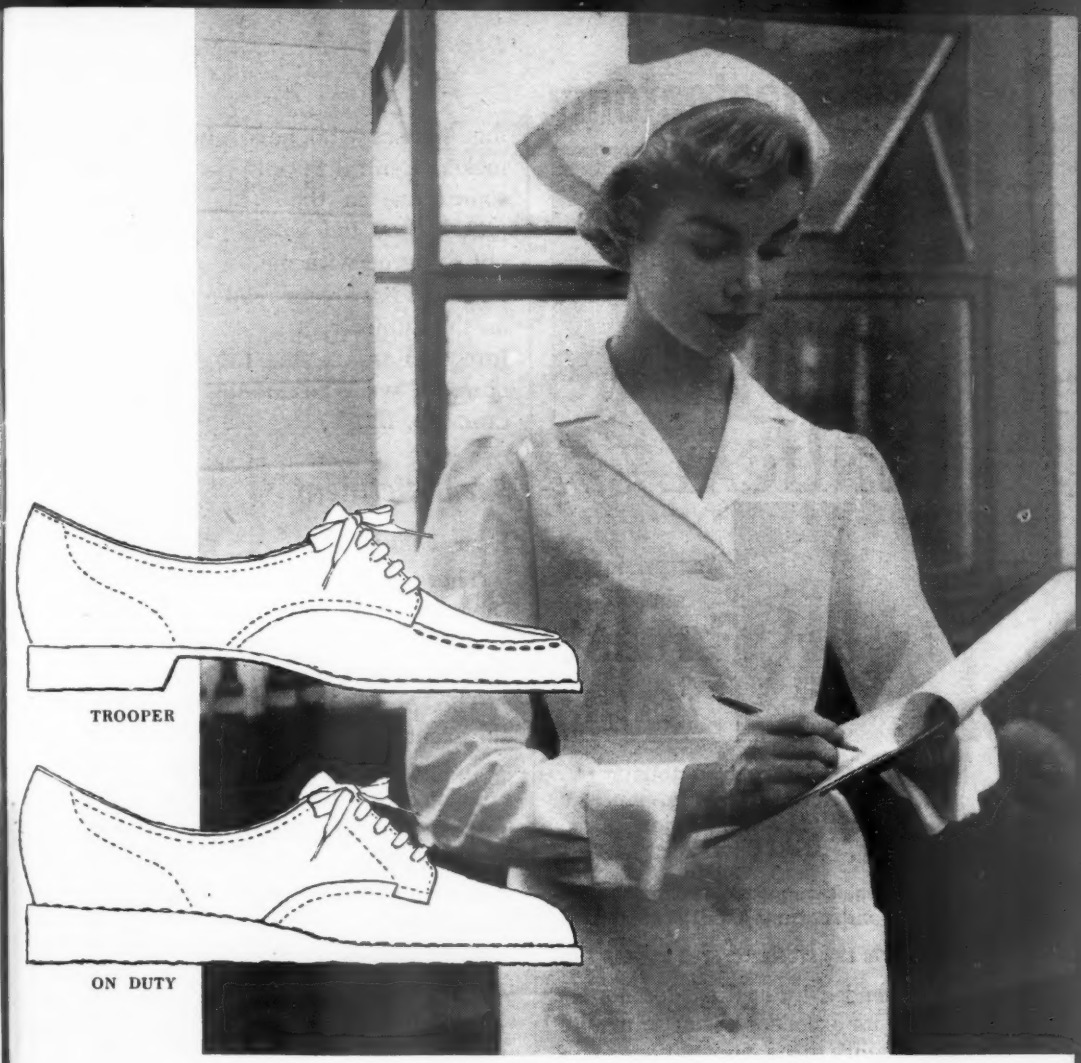
Forgotten Department

Dear Editor:

Although a few articles have been published on "Central Supply," I feel that this branch of hospital work is a forgotten area. Years ago, the department was a "catch-all"; but as hospitals progressed, they realized the value of a well-organized service.

As head nurse in Central Service here, I believe more R.N.'s should be interested in organizing such departments and working therein. I can say from experience that Central Supply no longer is a place where R.N.'s are utilized simply because they can't adjust in other areas, but a place where they can give excellent nursing care indirectly. It's just as important as the switchboard, which is considered the nerve center of an establishment.

Here an R.N. must have endless initiative, be conscious of cost, be constantly eager for research, and spend every available moment teach-



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ing. Nurses who have always overlooked Central Supply should spend some time in the area; like many others, they, too, would then be more apt to agree with me.

May I have your readers' opinions on this subject?

JOHN J. FRENCH, JR., R.N.
LOUIS A. WEISS MEMORIAL HOSPITAL
CHICAGO, ILL.

An Indictment

Dear Editor:

There is no true shortage of registered nurses. It is the profit-hungry hospitals that are creating an artificial shortage.

The professional experience and conscientiousness an R.N. may bring to her patients are taken lightly. To save money, hospitals hire practical nurses, or aides, with a registered nurse in charge, and feel complacent that the patients are receiving good care.

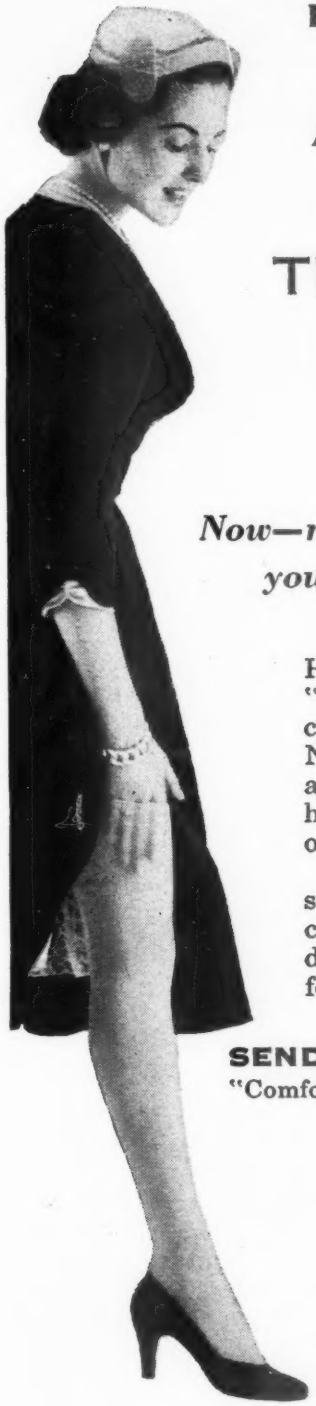
Until hospital administrators realize the importance of good nursing care, and the necessity of paying a decent salary to secure this care, the "shortage" of registered nurses will continue.

RUTH JOHNSTON, R.N.
CHALMETTE, LA.

Helpful Idea

Dear Editor:

Judging by the questions asked by our plant employes, it is evident to me that there is a great need for health education in industry, and I feel it is the industrial nurse's duty to



FOR VARICOSE VEINS
FROM BAUER & BLACK

AN ELASTIC STOCKING THAT DOESN'T LOOK LIKE ONE

Now—nylon elastic stockings so sheer you can wear them without overhose
(and they give you perfect support, too!)

Here at last is an elastic stocking without that "wooden leg" look. One that keeps your varicose veins a secret—even without overhose! New Bauer & Black nylon elastic stockings are so sheer they won't show under uniform hosiery. Off duty, you can wear them without overhose.

They're fashioned to assure you of correct support from ankle to thigh. Open-toe for comfort. Won't discolor. Easy to wash. Quick drying. Light and cool. Wouldn't you, too, feel better in *these* elastic stockings?

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help in this regard. So, after reading **R.N.** and other nursing journals, I clip whatever health articles I think would be interesting and helpful to employes and their families, then place these clippings in folders in a reading-matter rack which has been provided in the waiting room of our plant health department. Our employes have little time for reading during the working day, but many times they ask to take an article home, and the borrowed clipping is generally returned.

I enjoyed very much the article, "Now I've Had Industrial Experience," in your July issue. I passed it on to our personnel manager and others on our staff, and they, too, appreciated it. It brought to mind the many times in my own experience when an injury wasn't reported because it happened just as the lunch bell rang or it occurred just before quitting time.

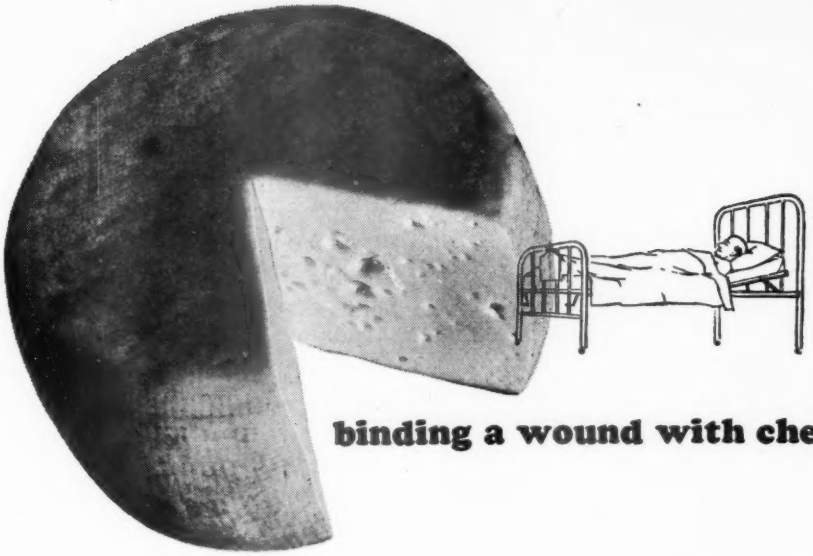
(Mrs.) MYRTLE HAIDL, R.N.
BATTLE CREEK, MICH.

"Can't Happen Here"

Dear Editor:

Is it too late for a rebuttal to a letter in your May issue? The writer says she was told that her state officers feel there will be "no such thing as private duty" in two years. (She wrote from California.)

Expert nursing care is even more necessary today than it was 25 years ago—especially in polio centers, industrial areas, and wherever neurosurgery or chest surgery is done. Lack of such expert care would often



binding a wound with cheese

A wound is as strong as the connective tissue that holds it together...and the maximum strength of a wound is reached more rapidly when the diet contains liberal amounts of protein for growth of connective tissue. [1]

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Cheese is likewise indicated for its high protein value in the geriatric diet[2] and whenever low tissue protein stores are suspected, not only in poorly healing wounds but also in patients with bed sores, chronic bullous diseases, atopic dermatitis, and senile pruritus.[3]

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High palatability, pleasing texture and delicious flavor, characteristics of Borden cheeses, stimulate the appetite and contribute to greater eating enjoyment for both the convalescent and other members of the family.

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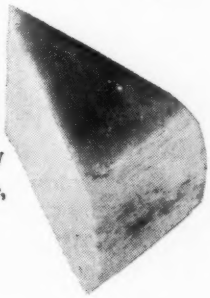
1. Baborka, C. J.: Treatment by Diet, ed. 5, Philadelphia, J. B. Lippincott Company, 1948, p. 607.

2. Sebrell, W. H., in Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, W. B. Saunders Company, 1949, p. 194.

3. Morgan, D. B.: J. Missouri M. A. 49:896 (Nov.) 1952.



The *Borden* Company
350 Madison Avenue,
New York 17, N. Y.

jeopardize the life of the patient.

Add to this the fact that more and more hospitals use more and more aides and practical nurses for routine bedside care. Those who can afford to indulge themselves when ill will not give up the luxury of private duty care merely because somebody said thus-and-so. Many such patients dislike the constant stream of new faces in and out of their rooms; they avoid it through the use of private duty nurses.

If this last vestige of true bedside nursing is taken from the R.N., can we continue to call ourselves nurses? Or should we more properly be called medical technicians?

The expert knowledge of the private duty nurse will be needed so long as there is life on this earth—the prognosticators of doom notwithstanding. Thank goodness, *my* state officers are much more far-sighted and realistic.

(Mrs.) Helen Bach, R.N.
EUGENE, ORE.

She'll Risk It

Dear Editor:

I see that **R.N.** and other nursing magazines are putting more and more stress on malpractice insurance. I hate to see us being talked into it by insurance companies who are interested only in our money. A nurse scared to practice without insurance had better take up another form of work in which she is more confident of her abilities.

Apparently, the insurance companies, by keeping the topic fresh in

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...WITHOUT BRUSHING!

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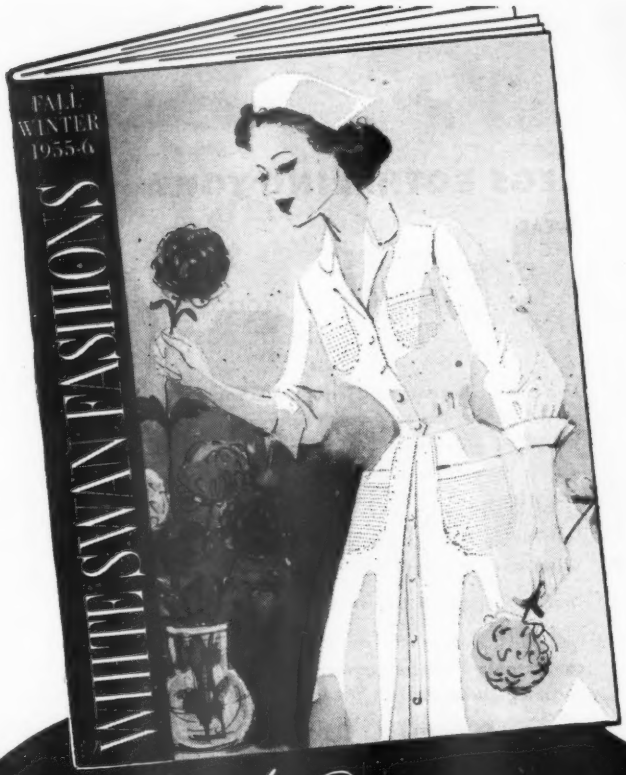
our minds and, at the same time, by cleverly making us believe that we, ourselves, thought of it and need it, are doing a good job. But doesn't every nurse already carry a heavy enough insurance burden? Soon we'll even be afraid to breathe without air insurance!

The more you print about malpractice insurance, the more fear you instill in us—fear of being sued. And as soon as the public realizes that such insurance is available, we'll find ourselves being sued, too. Yet in my 22 years of continuous nursing, I've never heard of a malpractice suit being brought against any nurse I've ever known or against her hospital because of her. Let's not be suckers!

CHRISTINE NEWMAN, R.N.
LIMA, OHIO

[*Nurses are under no compulsion to purchase malpractice insurance but, as the writer states, nurses are being urged to avail themselves of this protection. The reasons are becoming increasingly obvious. One is that nurses have to deal with a more suit-conscious public. Another is that as nursing is recognized as a profession, its members are no longer protected from personal liability. As professional people, they are legally responsible for their own acts. Although you, or your co-workers, have encountered no law suits, there are enough claims against nurses to warrant this insurance. An important point to bear in mind is that malpractice insurance pays legal expenses of defense against unmerited claims as well as damages resulting from successful claims.*—THE EDITORS]



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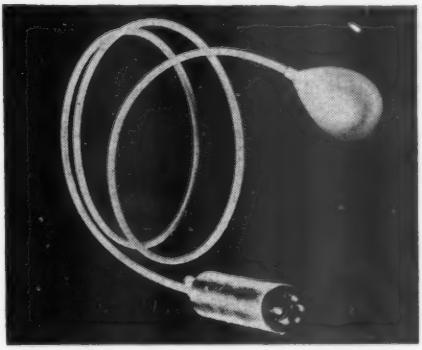

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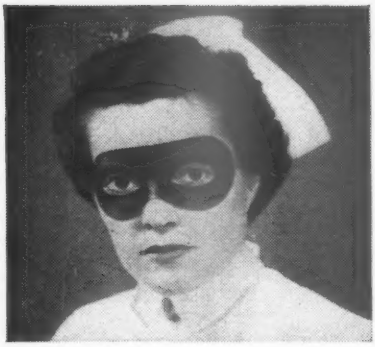

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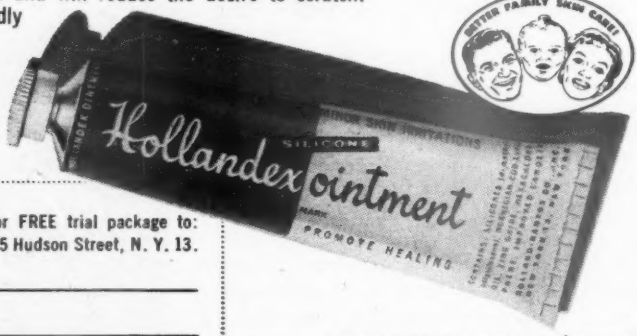

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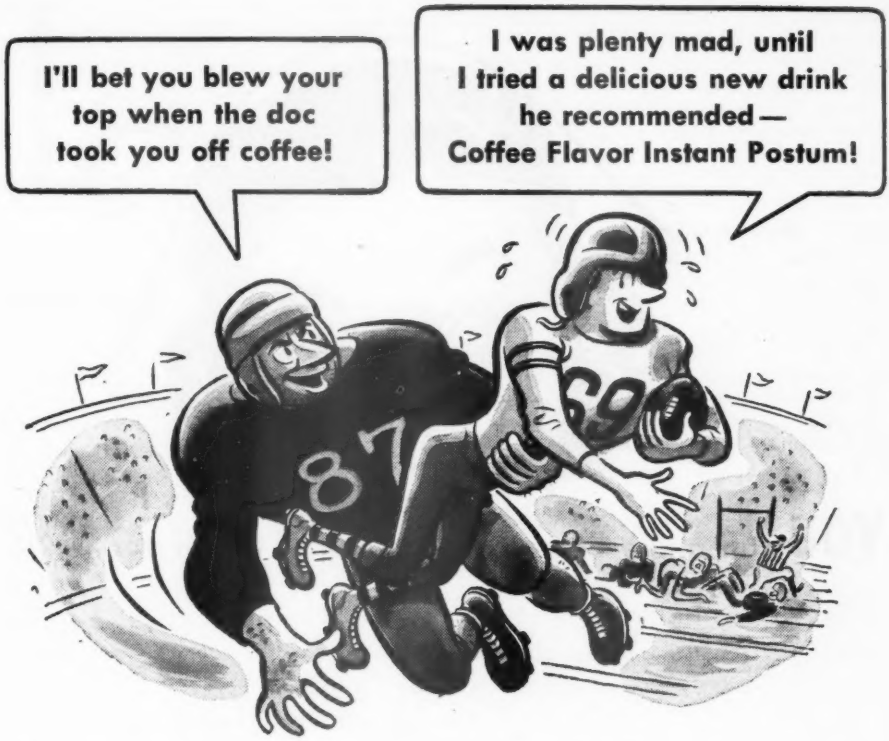

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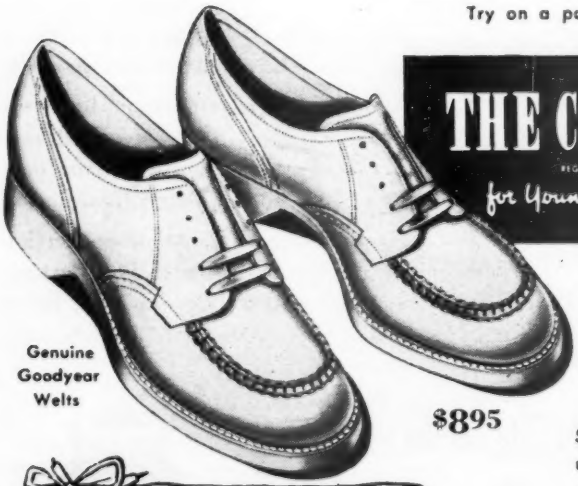

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HOW TO STERILIZE SURGICAL GLOVES: Here's a handy set of instructions printed on card stock of a size convenient for posting in a conspicuous place. The card tells the whole story about proper cleansing and sterilizing of surgical gloves. Nurses may find it useful for reviewing their own procedure or for instructing other personnel. THE PIONEER RUBBER CO. **K 2**

DIABETES CONTROL: This folder tells of the use of the Denco Urinalysis Kit in the routine control of diabetes. One feature is a set of color charts indicating determinations for evidences of sugar and acetone. THE DENVER CHEMICAL MFG. CO., INC. **K 3**

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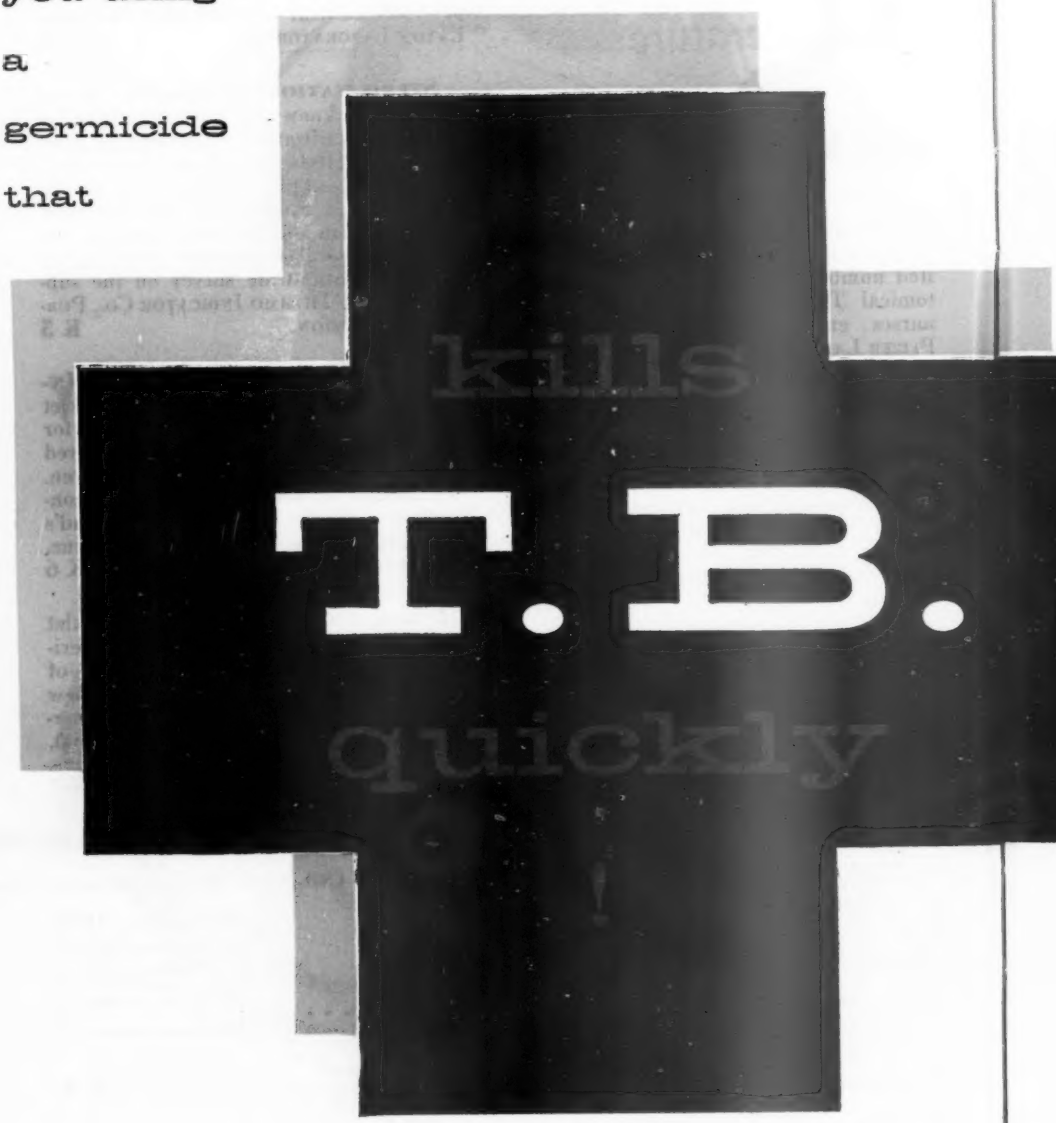
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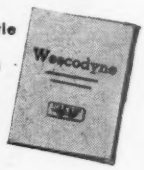

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BROAD SPECTRUM ANTIBIOTIC THERAPY, EFFECTIVE IN MANY COMMON INFECTIONS

Because it contains Steclin (Squibb Tetracycline), MYSTECLIN is an effective therapeutic agent for most bacterial infections. When caused by tetracycline-susceptibile organisms, the following infections are a few of those which can be expected to respond to MYSTECLIN therapy:

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In clinical use, Steclin has produced an extremely low incidence of the gastrointestinal distress sometimes observed with other broad spectrum antibiótics. Mycostatin (Squibb Nystatin), as contained in MYSTECLIN, is also a particularly well tolerated antibiotic and has produced no allergic reactions, even after prolonged administration.

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New evidence shows that because of calcium-protein antagonism, calcium phosphate supplements may actually cause a deficiency, just when optimum levels are desired. And high-protein diets are also rich in calcium-draining phosphorus. Thus leg cramps are a minor symptom of major significance: they may indicate seriously low calcium.

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Dosage: Two tablets three times daily.

Available: Bottles of 100 tablets and in 8-ounce nursing bottles of 300 tablets.

*Wolff, J. R.: Illinois M. J. 105:6 (June) 1954.

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RATIOS WITHOUT RELEVANCY

■ AT ATLANTIC CITY'S Convention Hall, time ran out, and nursing's round-table discussion in Room 13, "Basic Considerations in Determining Staffing Needs," was over. This was the panel's second performance at the American Hospital Association convention, and a third would be given next day. Yet the topic still was running a close second to the most popular of some 100 round-table sessions scheduled. The most popular? "Credits and Collections," naturally—for these were hospital administrators meeting; the business men and women of the hospital field; the individuals who experience palpitations of the budget at the glimpse of a new balance sheet or laundromat.

As we emerged from the crowded room, I struck up a conversation with a hospital administrator walking beside me. My opening gambit was: "Pardon me, sir, what do you intend doing with those nurse-staffing figures given out at this meeting?" He came out of his meditations with a jolt; gave me a quick, puzzled glance and answered: "Use them. I'm taking them back to my hospital. Maybe now I can prove to the doctors that our ratio of graduate to practical nurses is not out of proportion. I'm sure our ratio is higher."

A yardstick which would assure adequate nursing care was offered by a member of this nurse panel—a ratio of 1.99 professional nurse-hours to 1.91 non-professional nurse-hours, totalling 3.9 hours of nursing care per patient per day. As one, all heads bent over note pads as these figures were jotted down. Here was the answer to their unasked question of how *do* you determine staffing needs. Here was the new measuring rod they had been waiting for.

The panel gave out more figures on staffing and sizes of units, together with cautions as to the use of these figures; but I'll venture an educated guess (*phrase du jour*) that the cautions weren't noted with as much alacrity as were the figures.

Interestingly enough, there appeared to be much more unanimity among the panel members on the ratio of professional to non-professional nurses than on what should be the ideal size unit for staff-

EDITORIAL

ing purposes. Members of the audience were told that they should ask themselves two questions: (1) What is the maximum number of patients one night nurse can take care of? (2) What is the maximum number of patients one head nurse can take care of? However, when the panel members approached these questions, they came up with various maximums: 40 to 46 beds; 30 to 35 beds; 24 to 32 beds.

The open discussion brought out that the differences in opinions here were due to the considerations of varying conditions: (1) the hospital construction—new, old, compact, or sprawling; (2) type of hospitals—general, government, chronic or acute disease, etc.; (3) types of units—open wards, private- or multiple-bed rooms.

The questions uppermost in my mind following this discussion are: Why were not these variances considered when the ratio of professional to non-professional care was given? How can such a yardstick be applied if only the number of beds and size of units are considered? What about the occupants of those beds and units? Will the 1.99:1.91 ratio assure adequate patient care if the hospital happens to be located near an accident-plagued highway; if the census is composed of a predominance of acutely ill patients; if the surgery schedule is extremely active? But, to my mind, statistical thinking and emotional thinking are at the opposite ends of the pendulum; both, therefore, are unsatisfactory means to a solution.

Are nurses rendering a service or disservice when they compute hours of nursing care per patient-day as a guide for the staffing of hospitals? Can there be such a thing as a universal staffing yardstick? One professional or non-professional nurse does not necessarily equal another in performance. And isn't it a theoretical absurdity to put stock in a numerical yardstick when human beings with their differing personalities and capacities are involved? Granted, patients and nurses may be added, subtracted, and multiplied; but how successful is any hospital [*Continued on page* 75]

THE AMERICAN HOSPITAL IN PARIS

by Evelyn Pastore

■ SOMEONE has called it "The Nurses' U.N."—and not without good reason: Its ninety-seven nurses come from the U.S., France, Britain, Canada, Sweden, Denmark, Ireland, Holland, Switzerland, and Finland; its nursing director hails from Australia; and its educational director is Russian by birth. Yet you could go on duty at the 155-bed American Hospital in Paris and feel right at home in a matter of minutes.

You'd find the medicine cards, the surgical dressing cart, the patients' charts, the sterile supplies, and all else as you've always known them. From the top-floor operating rooms to the basement kitchens, you'd find everything modern, everything American: the newest operating tables, soundproof rooms, a deep x-ray installation, a tomograph, and stainless steel kitchen equipment. Here in Neuilly-sur-Seine, a quiet Paris suburb, you'd find a hospital set in a veritable country estate, shaded by tall trees among well-kept gardens.

Established in 1910 with a mere

ten-bed capacity, this hospital endeavors to provide the best in American medical care for Americans abroad, regardless of their financial status. It is a member of the Blue Cross Associated Hospital Service plan and is accredited by the Joint Commission on Accreditation of Hospitals of the United States and Canada. In 1953, the hospital services totaled 50,000 patient-days, with admissions of non-Americans supplementing those of U.S. nationals, both civilian and military.

Despite the international flavor of its nursing staff, the hospital's dominant influence on nursing practice is definitely American. (Until 1934, it maintained its own training school under the direction of American nurses from two of New York's largest teaching hospitals.) But good nursing knows no national boundaries, and one of the most striking points about the American Hospital is the harmonious way in which its nurses work together. No difficulties of any kind arise over national differences, according to its superintendent of nurses; good teamwork is assured by careful indoctrination of all newcomer nurses under the supervision of the hospital's educational director, Miss N. Maximoff, who recently spent several months studying at Wayne University Hospital in Detroit.

Left: Garden view of "the Nurses' U.N," as this 155-bed hospital in the Paris suburb of Neuilly-sur-Seine has been called. Below: Information desk in the main lobby.

There's rarely a time when the hospital hasn't its quota of U.S. nurses. Right now, Cynthia Cavell and Elizabeth Hunt, Yale University School of Nursing, 1952, are rounding out a year's tour of duty. They live in the ultra-modern nurses' home built only two years ago. The Arc de Triomphe, the resplendent Champs Elysees, and all the rest of fabulous Paris are within easy reach by bus. And on off-duty days, the girls enjoy side trips to innumerable points of interest in the Ile de France and the provinces.

The hundreds of U.S. nurses who saw duty at the American Hospital during World War I, when it was the American Red Cross Hospital Number 1, and World War II, when the 365th Station Hospital took it over, can recall the allure of Paris. Their services and the valiant work

of French and Swiss nurses, who kept the American Hospital functioning during the German occupation of France, have contributed greatly to the hospital's distinguished wartime record. For its care of the wounded before the fall of France in 1940, the hospital was cited with the Order of the Army by the French government, and its present Director of General Services, Miss E. Comte, was specifically mentioned in the citation. Swiss by birth, Miss Comte will tell you that the happiest day in her life came with the liberation of Paris, when she and other nurses rushed to the hospital roof to hoist the American flag which they'd kept hidden during the entire German occupation of France.

There's much to anticipate—and some disadvantages to consider—if you're thinking of spending a year here. Salaries in France are much lower than in the States; the average Frenchman earns about $90 a month in our money. At the hospital, a nurse's base pay is 31,000 francs ($88) a month. Out of this she must pay 1,100 francs ($3) a month for her room and 6,600 francs ($18) for meals. Those who speak French fluently (and some knowledge of it is obligatory) earn a bonus of about $10 a month. Even so, one's salary, after room and meals are deducted, leaves little for wild spending, and Paris is about as expensive in this respect as New York.

Staff nurses work a 48-hour week, eight and a half hours a day on a split-shift arrangement to stretch out the time-off periods. Thus it becomes possible to "have off" what amounts to one and one-half consecutive days. The night shift—an 11 and one-half hour trick—runs from 7:30 p.m. to 7:00 a.m., with two nights a week off and overtime pay for the extra hours.

Counterbalancing these seeming disadvantages is the opportunity to live in Paris, to work in a world-renowned hospital, and to care for its many illustrious patients—a list of whom would read like an international "Who's Who." The hospital's high medical [*Continued on page* 77]

Science and Semantics

● **INTERLINGUA, a new form of communication for scientists from different countries, was used in abstracts of scientific papers presented at the Second World Congress of Cardiology, held in Washington, D.C., in September, 1954. Unlike Esperanto, which is an artificial spoken and written language, interlingua is not spoken, and is a combination of all the common elements of the Western languages now in use, chiefly Spanish, French, Italian, and Portuguese. German words and forms are not used. Persons familiar with the Romance languages have little difficulty in reading it, but it is more difficult for those with only a knowledge of English.**

AHA CONVENTION HIGHLIGHTS

Ruth M. Sleeper of Boston, Mass. was awarded honorary membership in the AHA at its fifty-seventh annual gathering.

Photo: Loring Studio

■ SOME 7,000 hospital administrators and allied health workers braved hurricane warnings to meet in Atlantic City, September 19-22, for the 57th annual convention of the American Hospital Association. Carrying out the convention theme, "Working Together for Better Health," the meeting featured general sessions on hospital relationships and nearly 100 round-table discussions—a program innovation—on the specific problems of hospital operation and hospital administration.

For the disaster-minded, program planners provided two civil defense sessions and, as a further boost to national preparedness, AHA delegates urged the Federal Civil Defense Administration to increase the number of "impro" (improvised) hospitals for emergency treatment of disaster casualties. How the armed forces can meet the needs of combat casualties was shown in two full-scale exhibits: a 36-bed, air-transportable infirmary, and an ambulance railway car.

More immediate problems, such as financing patient care, were explored by convention speakers during general sessions. In dutifully paying tribute to Blue Cross' 25th anniversary this year, it was acknowledged that Blue Cross must meet future health needs, including extended care for long-term illness, convalescent care, diagnostic service, and home nursing, as well as facilities for "positive health." But a warning note was sounded: There must be safeguards against abuse; otherwise, prepayment insurance will price itself out of the reach of the ordinary working man. [*Why wasn't nursing represented at these meetings to ex-*

plain its goal of including nursing in prepayment health plans?]

Just how the needy should receive tax-supported personal health services has been spelled out in a joint statement of principles approved by a committee representing the AHA, the AMA, the ADA, the American Public Health Association, and the American Public Welfare Association. At this convention, AHA delegates officially approved the statement which designates "personal health services" as services of physicians, dentists, nurses, and other hospital personnel, in addition to hospital care, laboratory services, drugs, and appliances. According to the statement, financing of these services should be assumed by appropriate government units; it urges equitable payment for services and says that payment to institutions should be based on the full cost of services. The latter principle aims to relieve budget headaches of hospitals now inadequately compensated for the care of indigent patients. [*Why was no official nursing organization involved in the formulation of this statement?*]

That there is a gap between the health services that the general hospital should provide and the services currently available was brought out repeatedly throughout the convention. The hospital of the future was envisioned not merely as an institution for the acutely ill but as a community health center offering a wide range of in-patient and out-patient care. Perhaps this point was made most succinctly by USPHS Surgeon General Leonard A. Scheele, who observed: "The administrator is directly concerned with the daily exigencies of meeting the payroll. But he must also exert leadership in the coordination of his hospital with other medical and health services in the community."

Relegated to discussion groups this year, nursing was represented at round tables on "Basic Considerations in Determining Staffing Needs," chaired by Margaret Giffin of the NLN; "Rehabilitative Aspects of Comprehensive Nursing Care," under the direction of Marion W. Sheahan of the NLN; "The NLN Accreditation Service," led by Helen Nahm of the NLN; and "Practical Nursing," chaired by Mildred L. Bradshaw, director of a school of practical nursing in Norfolk, Va. Two other round tables presenting nursing problems were "Eliminating Operating Room Bottlenecks" and "Dispensing Drugs at Night." Of all these sessions, the thrice-repeated round table on nurse-staffing drew the largest attendance. (See editorial, page 34.) [*In view of the interest aroused in nurse-staffing, shouldn't this subject have been included in a general AHA session?*]

Nurse-staffing also came in for its share of attention in a round table discussion of practical nursing where hospital administrators were encouraged to set up practical nurse schools. One advantage of practical nurses, it seems, is the low staff-turnover among this group. In one hospital, it was reported, practical nurses are responsible for most of the bedside care while aides perform duties not requiring the [*Continued on page* 78]

Code of Ethics*

1. The fundamental responsibility of the licensed practical nurse is to endeavor to conserve life and to promote health, with the welfare of the patient the main concern.

2. The licensed practical nurse must be adequately prepared to practice and should take advantage of all educational programs which would further nursing knowledge.

3. The licensed practical nurse should know his or her limitations and should stay within the bounds of those limitations.

4. The licensed practical nurse should at all times present an appearance that would reflect credit to himself or herself and to the profession.

5. The licensed practical nurse must respect the patient's race, color or creed at all times, and hold all information in strict confidence.

6. The licensed practical nurse should carry out unselfishly the prescribed care necessary to promote the health and comfort of the patient.

7. The licensed practical nurse should seek advice and clarification if in doubt as to the prescribed procedure or uncertain as to ability to carry out the procedure.

8. In hospital employment, the licensed practical nurse must abide by the policies of the hospital, accepting only such compensation as the contract implies. A licensed practical nurse should not accept or expect tips or bribes.

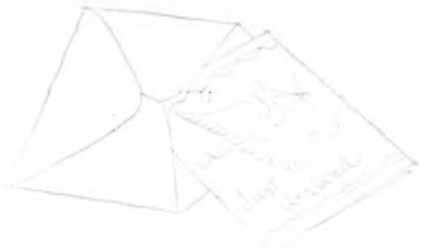
9. The licensed practical nurse should be loyal to the physician in charge and to all members of the health team; and in association with them should apply the Golden Rule, refusing to participate in any unethical conduct.

10. In private life, the licensed practical nurse should adhere to high standards of personal ethics which would reflect favorably upon the profession and promote the welfare of the community.

11. The licensed practical nurse should share responsibility with other citizens and health professions in promoting efforts to meet the health needs of the public on a local, state, and national level.

12. The licensed practical nurse should maintain membership and actively participate in the local, state, and national organizations; and consider himself or herself a committee of one to promote membership in the practical nurse organizations.

*Adopted at the 1954 convention by the Practical Nurses of New York, Inc.



FIRST BABY

■ MOTHERHOOD is no longer the exclusive hope of younger women. U.S. birth records for a recent year show that a surprising number of women—6,297—became mothers for the first time at age 40 or over.

Better nutrition, the practice of proper personal hygiene, and our American sense of good grooming have all been cited as contributing factors in this trend toward childbearing in early middle life. But whatever the reasons, the authorities agree that the American woman of 40 is no longer old, and that intellectual maturity is a decided asset for parenthood.

During pregnancy, however, the expectant mother who has married (or re-married) in her late thirties or early forties tends to be tense and fearful about possible complications. As nurses, we can do much to ease her mind by pointing out that numerous advances in the medical sciences are now available to her—techniques and drugs which didn't exist fifteen or twenty years ago.

Complications that might develop can now be handled with improved operative procedures, pharmacology, and anesthesia. Antibiotics, including penicillin and streptomycin, stand ready to combat infection. Other drugs, the oxytocics, can be called upon to help the action of the uterus and prevent bleeding.

Further reassurance can be offered in the fact that obstetricians have found no abnormal incidence of toxemia or high blood pressure among expectant mothers in the upper age group. (The incidence is not very high at *any* age.)

In a study at George Washington University Medical Center, an obstetrician reported no increased rate of premature births among older mothers. His study included women who were having their first, second, and third children.

"Older women are surprised to find their chances are the same as those of 24-year-old women," says this obstetrician. "There is no contraindication at all for a healthy woman over forty."

Most obstetricians advise a natural delivery, rather than a Caesarian section, if the birth canal is adequate and the baby normal in size. Some, however, favor the Caesarian method. A New Haven (Conn.) specialist, for example, states that women of 40-plus giving birth for the first time may not "bounce back" as quickly as those in their twenties. (Age lessens the elasticity of the tissues.) He feels, therefore, that an elective operation may be much better than a

AFTER 40

long, drawn-out labor and delivery.

In examining the older mother-to-be, the physician will naturally pay special attention to heart, lungs, and pelvic structure. After recording pelvic measurements, he may order an x-ray of the pelvis. The patient's blood will be typed, its Rh factor determined, and a complete test made to detect any possible anemia, venereal disease, or dyscrasia. Urine specimens will be screened for indications of diabetes or high blood pressure. For women over 35, microscopic examination of urine is suggested to track down any bacterial infection of the kidneys or bladder.

Physicians also pay special attention to the weight gain of the mother-to-be in relation to her body structure. Fifteen to twenty pounds is considered a normal gain by the end of her pregnancy. Often a special diet is recommended, with vitamin or mineral supplements if needed. Personal hygiene is similarly emphasized, and the patient is advised not to participate in any sport where she is susceptible to injury.

Generally speaking, the doctor sees his patient regularly at four-week intervals until the sixth or seventh month of her pregnancy; then she is asked to check in every two weeks; and in the last month, she reports weekly. This schedule, of course, is subject to the individual needs of the patient.

In the New Haven area, one out of every 300 pregnant women seen in hospital clinics is having her first

by Annette Rich

baby after 40. Yet the ratio of such mothers in that locality may actually be much higher, since most older women prefer a private physician to clinic service for their first born.

The fertility factor, of course, is apt to be a problem for some in the 40-plus group. "After 40," says one obstetrician, "a woman realizes that her reproductive years are numbered. Hence, if she wants a baby and doesn't conceive in a short time, she should (and generally does) seek immediate medical advice about her apparent infertility."

From the nurse's viewpoint, the all-important advice to offer the older woman is this: *Before you contemplate motherhood, have a complete physical evaluation.* If wife and husband are both in good health, pregnancy is rarely a medical problem because of age.

Recently I talked with several older mothers who had been childless when they reached age 40. One, a nurse of 48, is now the mother of a lively five-month-old boy. She had married when she was 38, and two previous pregnancies had ended in miscarriages. Yet she had no difficulty during her third pregnancy, and the baby weighed ten pounds when he was born.

"I worked on a private home case until almost time for the baby," this nurse-mother told me. "He was delivered by Caesarian section. I have always been healthy, and I felt fine throughout the nine months. Everyone in town followed my progress closely, since all were amazed when they heard I was going to have a baby. As a matter of fact, my husband and I were, too!"

This mother is now back on private duty with her former patient, and—wonder of wonders—is allowed to fetch Baby along!

Another woman I talked with told me that she had married at 35, but for personal reasons had remained childless for six years. Now in her forty-second year, she is the mother of a healthy three-month-old daughter. Confident in her choice of a good obstetrician, this mother said that she felt safe and secure throughout her pregnancy, remaining at her work (dress designing) until her seventh month.

"I kept an eye on my weight," she added. "I gained half a pound a week, and was not supposed to go over 150 at the end of the period. I made it—well, that is, with two pounds to spare! I wondered how I'd feel in hot weather. But I found that I felt wonderful carrying a baby. My associates at work kept telling me how well I looked. And I did my own housework, too! I was just a little uncomfortable toward the end."

Her doctor decided on a Caesarian delivery, and she had a good recovery. A visiting nurse helped with the care of the baby for the first few weeks. And now this mother and her husband are looking forward to having another child.

A third woman, who had married at 30, told me that she had tried to become pregnant for eight years. Finally she consulted a specialist, who discovered that she had two fibroids in her uterus. After removing

them, he assured her that her reproductive organs were in excellent condition—and at 40, she became the mother of a fine baby girl.

Admitting that motherhood had made a great difference in her life, she informed me that she had been in industry for many years. "I enjoyed my job," she said, "and continued to work until my fifth month, commuting daily. I never felt better in my life. I had no morning nausea or other discomfort. And the baby was delivered naturally.

"I now lead an entirely different life than I did when I was commuting to work every day, and sometimes I feel a bit tied down. But I have a wonderful husband, a healthy child, and I wouldn't want to have missed the happy experience of becoming a mother."

In conclusion, let me quote a medical consultant. "Nurses," he said, "may encourage any woman in her forties who wants a child to go ahead and have it after placing herself in the hands of a good obstetrician. I've never been wrong in that advice."

But, he was asked, can women past 40 hope to keep up with the boundless energy of small children?

"Don't women of 20," he replied, "have trouble doing that?"

• • • speaking of doctors

● ONE OF THE most unforgettable physicians I ever met was the late Dr. Edward P. Carlton of Windsor Township, Wisc. Not only brilliant, but ruggedly individualistic, he was truly unselfconscious—a real extrovert.

At one time, he had been a medical-school teacher; in fact, he never stopped being a teacher. He liked nothing better than to reach into his library shelves, pull out a book setting forth some authoritative opinion on a medical subject, and then offer a better one—his own.

I arrived at his office one day to discuss a school-health problem. (I was doing rural public health work at the time.) The waiting room was filled, and I sat down to take my turn; but he saw me and beckoned me into his office.

A half-hour later, he was still talking, drawing diagrams, and explaining all angles of the disease under discussion. I politely rose to go, but he motioned me back to my chair. Finally I said, "But Doctor, what about your patients?"

He stood for a moment in silence. Then he opened the waiting-room door, looked the patients over carefully one by one, and issued a surprising "prescription": "Go home, all of you," he said. "There isn't a damn thing the matter with anybody here!"

Leaving the door slightly ajar, he resumed his lecture to me—talking as though he were addressing a roomful of medical students, and as if all future life hung on his words.

When I finally managed to get away an hour or so later, heavy with knowledge and guilt, those patients were still sitting there in the waiting room. No doubt they, too, had enjoyed the lecture; at any rate, they certainly knew and understood their beloved doctor.

As I closed the outer door, I heard him say—as if there had been no interruption whatever in his afternoon's work—"Next!"

—GURO BJORNSON, R.N.

■ THE SHOCKING INCREASE in juvenile drug addiction since World War II has merited many headlines, and wide attention has been focused on the problem. Less well known is the story revealed in the records of numerous state licensing boards: a startling increase in the number of nurses, doctors, and pharmacists addicted to drugs.

Despite official warnings, many with the legal right to handle narcotics seem to be unaware of the hazards involved in their misuse. This may be due, in part, to the mistaken notion that drug addiction is limited to the "criminal classes."

Frequent stories linking the addict to crime of every kind have fostered the idea that he is inherently criminal-minded. This view, however, is not borne out by the facts. Nor do the direct effects of such drugs as morphine and heroin lead, in themselves, to anti-social behavior. As a matter of fact, a person under the influence of these drugs has little interest in activity of any sort, criminal or otherwise.

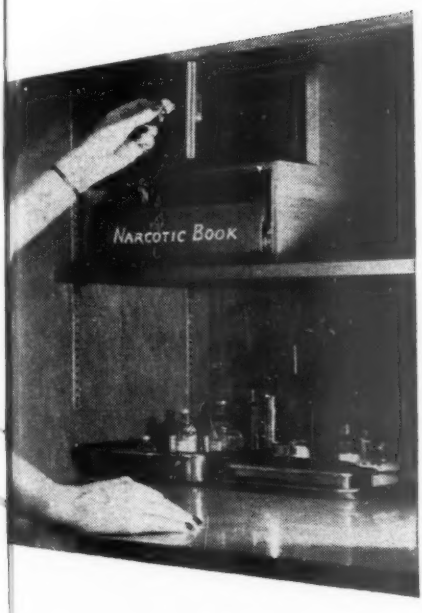
True, addicts become capable of lying, stealing, and killing in order to satisfy the overwhelming need for a drug when deprived of it; but these activities are the result, rather than the cause, of addiction. Actually, far from being snivelling, shaking degenerates, addicts are not essentially different from the rest of us. When getting an adequate daily dose of their drug, they can seldom be distinguished from "normal" people.

Who, then, are the people most likely to become addicted, and how

The Narcotic Problem

do they acquire the narcotic habit?

Potential addicts are present in all strata of society; they may be of any race or creed, and they display all degrees of intelligence. Yet more than 95 per cent of all addicts seem to share one common characteristic: a personality defect that makes it difficult to cope with the strains and stresses of daily living. For these emotionally unstable people, depressant drugs offer a means of reducing anxiety and offsetting the disappoint-



Among Nurses

ments and the frustrations of life.

Only a small fraction of people with predisposing personality traits ever become addicted because few have ready access to drugs. Nurses and doctors, unfortunately, come in contact with narcotics too readily. This propinquity, together with the nature of patient care (which burdens R.N.'s and M.D.'s with the difficulties of others in addition to their own), may account for the high incidence of nurse-doctor addiction—an incidence estimated at nearly a hundred times that of any other group.

The tragedy of addiction lies less in the organic damage drugs may do than in the fierce bondage into which the addict sells himself. Craving for the drug forces the addict to forego normal, socially fruitful activities. His whole existence seems to be motivated by the fear of not being able to obtain the drug, and this fear may force him into acts detrimental to both himself and society.

Pharmacologically, addiction is characterized by three closely connected phenomena: habituation, tolerance, and physical dependence. Habituation refers to psychic or emotional dependence on the drug. Tolerance is characterized by the fact that the addict must take more and more of the narcotic to obtain the same pleasurable effects he got from its initial use. After a while he may be taking many times the dose with which he began. For example: the repeated use of morphine may force one to take as much as five grams daily to experience a sense of well-being. Just how the body acquires the ability to handle such huge amounts is not fully understood, but recent evidence points to a biochemical basis.

Chemical changes in the body are believed responsible for the terrible tyranny of physical dependence, a distinguishing factor in the most vicious forms of addiction. This dependence means that the victim must have the drug in his system to keep

by Morton J. Rodman

his body functioning comfortably. When deprived of it for even a few hours, he becomes increasingly distressed and, finally, suffers the symptoms of a severe illness—the "withdrawal" or abstinence syndrome.

While the way in which this reaction is brought about is a pharmacological mystery, it is assumed that the body cells, especially those of the central nervous system, have so adapted themselves to the drug's presence that they cannot function without it. Whatever the cause, the importance of the phenomenon is the part it plays in keeping the addict in bondage. The misery he suffers if denied his accustomed dose makes self-cure impossible and drives him toward misdemeanor and crime.

The "withdrawal" syndrome may be brought on in its entirety in a few minutes, instead of many hours, by the administration of a new relative of morphine known as nalorphine. This drug, introduced originally as an antidote for narcotic poisoning, has the unique ability to precipitate the syndrome when a tiny dose is injected under the skin of those addicted to opiates and the newer synthetic narcotics. This rapid unmasking effect makes nalorphine extremely valuable as a diagnostic aid in determining the degree to which a suspected addict is dependent upon drugs. Caution is required, however, for the sudden severe sickness that nalorphine produces may endanger life, and the effects are not readily reversed, even by massive doses of the addicting drug.

Though useful in diagnosis, nalorphine is not effective in the *treatment* of addiction. Management of this complicated condition remains a difficult problem, requiring care for many months in highly specialized hospitals, such as those of the Public Health Service at Lexington, Ky., and Fort Worth, Tex.

First step in treating narcotic addiction is drug withdrawal. The procedure may be brutally abrupt or slow and prolonged. Immediate total abstinence, however, is seldom advocated today; it is considered to be both needlessly cruel and hazardous, especially in patients in poor physical condition. Presence of cardiac, kidney, or other organic disease may require a withdrawal period of many weeks.

At present, the most popular withdrawal method is rapid reduction for one or two weeks, with the aid of various supportive measures. At first, the patient is allowed a "stabilizing" dose, the minimum amount needed to prevent withdrawal symptoms. After a few days, the dose is reduced still further in accordance with a carefully planned schedule. Then, for another few days, a drug is substituted which causes a less severe syndrome than the original narcotic. Codeine has been the usual substitute until recently; now the synthetic analgesic, methadone, is also being used.

The symptoms that follow the withdrawal of codeine or methadone after a week or two are quite mild compared to those caused by complete withdrawal of morphine or heroin. Nevertheless, total abstinence

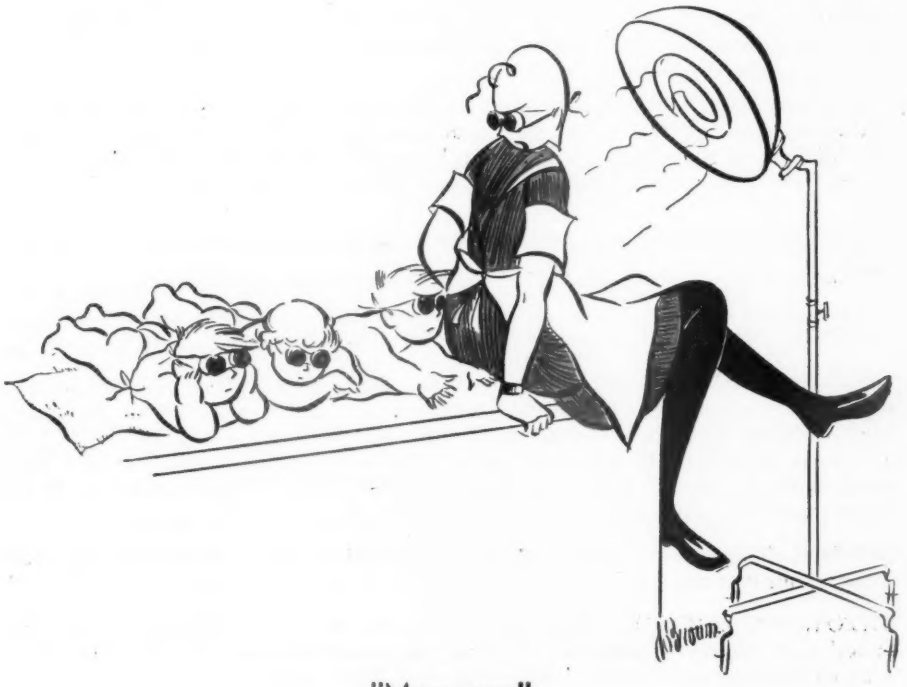
may be a physical and mental ordeal for many. Competent nursing care and supportive medical measures will do much to reduce the patient's misery and discomfort.

Supportive therapy includes drugs, diet, and physical measures. Sedatives such as chloral hydrate and paraldehyde may help bring about much needed rest and sleep. Warm baths and massage may also reduce sleeplessness and relieve muscle pain. To counteract gastro-intestinal distress, drugs such as bismuth subcarbonate are given, and ice collars and hot water bottles are applied.

To combat dehydration, fluids may have to be given—either as dilute fruit juices or, parenterally, as glucose in saline. A diet of readily digestible foods, together with vitamin supplements, must be maintained; the addict is often undernourished, and loss of weight during withdrawal is common.

While withdrawal may be accomplished in as little as ten days, breaking physical dependence does not end the treatment. Measures must still be instituted for psychological and sociological rehabilitation. Most patients remain in the hospital for at least five months, during which time intensive, [*Continued on page* 82]

Probie



"Move over."

Drug Digest

NALORPHINE HYDROCHLORIDE U.S.P. (Narcotic Antagonist)

PROPRIETARY NAME: Nalline

PHARMACOLOGY: Nalorphine is remarkably effective in treating poisoning caused by overdoses of morphine, methadone, meperidine, and other natural and synthetic opiate analgesics. It rapidly reverses or prevents the occurrence of the stupor, respiratory depression, circulatory failure, and loss of reflex activity that these drugs may cause. Giving the drug to morphine addicts can bring about a typical abstinence (withdrawal) syndrome.

DOSAGE: Nalorphine is administered parenterally in doses of 5 to 10 mg.; this dose may be repeated every 10 to 15 minutes up to a total of 40 mg., if necessary to increase the respiratory-minute volume.

UNTOWARD ACTIONS: High doses may cause nausea, sweating, drowsiness, and other minor ill effects. The drug should be used with caution in the diagnosis of addiction, as the symptoms of physical dependence that are unmasked may be severe, with serious consequences for addicts with organic disease.

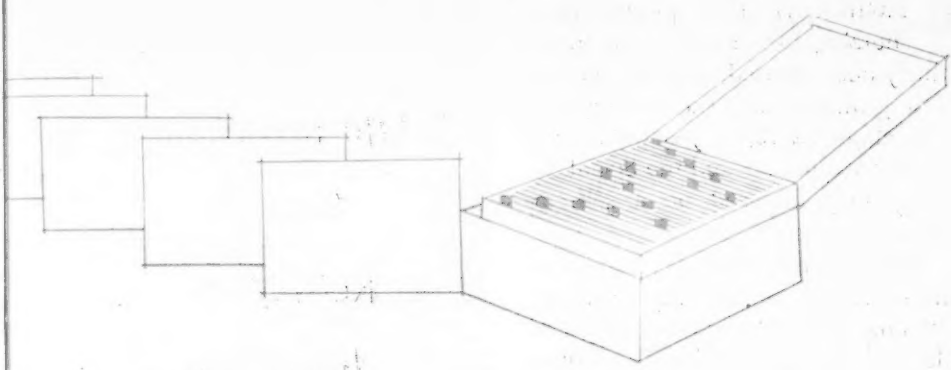
MEPERIDINE HYDROCHLORIDE U.S.P. (Synthetic Analgesic)

PROPRIETARY NAMES: Demerol, Dolantin, Pethidine

PHARMACOLOGY: Meperidine is used for the relief of pain in a wide variety of conditions, and may be combined with scopolamine or barbiturates for obstetrical analgesia and pre-anesthetic medication. Its chief advantage over morphine and other opiates is the lower incidence of side effects. The drug has also been employed to counteract bronchial spasm and contraction of the musculature of the lower gastro-intestinal tract.

DOSAGE: The usual dose of meperidine for relief of pain is 50 to 100 mg. every 4 hours, but this may vary.

UNTOWARD ACTIONS: Most side effects are minor and disappear with continued use. Heavy overdosage, even in addicts, may cause nervous stimulation with tremors, incoordination, excitement, and disorientation.



METHADONE HYDROCHLORIDE U.S.P. (Synthetic Narcotic)

PROPRIETARY NAMES: Adanon, Amidone, Dolophine

PHARMACOLOGY: Methadone is an analgesic of synthetic origin, with properties similar to morphine and other opium alkaloids. Methadone is used primarily for the relief of postoperative pain and the intractable pain associated with malignancy and other chronic diseases. In obstetrics, it is useful for the relief of postpartum pain, but may cause depression of respiration if used during labor. Methadone is an effective antitussive, but codeine is preferred because it is less likely to cause addiction.

DOSAGE: The drug is effective orally in doses of about 10 mg. and parenterally in still smaller doses.

UNTOWARD ACTIONS: While methadone is less likely than morphine to cause severe respiratory depression or addiction, both are dangers that must be reckoned with. It can cause all of the numerous side effects of morphine, including dizziness, nausea, and vomiting.

ALPHAPRODINE HYDROCHLORIDE N.N.R. (Synthetic Narcotic)

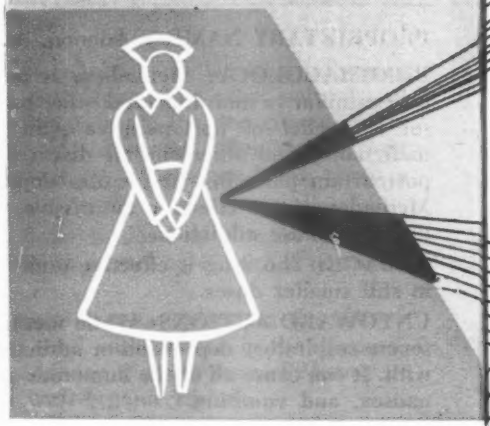
PROPRIETARY NAME: Nisentil

PHARMACOLOGY: Alphaprodine is used as a rapidly effective, short-acting analgesic in a number of obstetrical and surgical procedures, including labor, cystoscopy, and rhinoplasty. It is less likely than morphine to deeply depress fetal respiration.

DOSAGE: Alphaprodine is usually given subcutaneously in doses of 40 to 60 mg., depending upon body weight. Especially fast pain relief may be attained by intravenous administration of 20 to 30 mg.

UNTOWARD ACTIONS: Dizziness, sweating, itching, and some nausea and vomiting may occur. The development of tolerance indicates that this new drug is potentially addictive.

Life Insurance Can be Retirement Insurance



REGINA W. does private duty nursing in a small Ohio town. Thirty-one, married, and the mother of a growing boy, she manages to earn about $2,500 a year after paying her income tax and the Social Security levy imposed on a self-employed person.

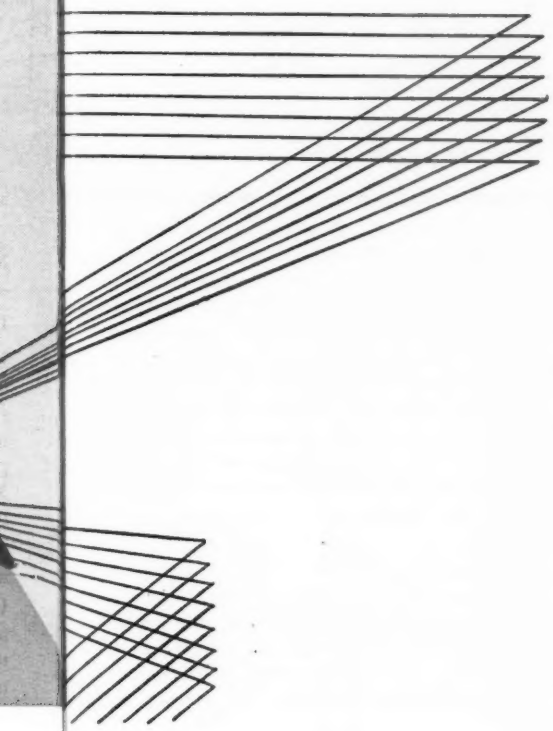
Until recently, Mrs. W. had given little thought to the way in which her financial circumstances might be affected by her husband's sudden death. She would, of course, still be able to earn her living as a nurse for many years to come. But what would happen when she reached retirement age?

Her Social Security benefits, she discovered, would probably not exceed $88 a month at her present rate of pay. Outside these benefits, she would have no other old-age income—unless she saved something in the meanwhile. She decided, therefore, to put 10 per cent of her earnings (or about $250 a year) into some form of savings immediately. "After all," she reasoned, "I'll surely be old for more than a tenth of my life."

So, from her local insurance agent, she bought a $5,000 life policy—the kind known as a "retirement income" contract. Her yearly premium payment on this policy comes to $205—though subsequent dividends should reduce this cost to about $180 a year.

When Mrs. W. reaches age 65, her policy will begin to pay her $50 a month, and this income will continue for the rest of her life, even if she lives to be 100 or more. If she should die before age 65, her beneficiary (husband or son) would receive the full $5,000—either in a lump sum or (if the beneficiary so wished) as income to be received regularly over whatever period he specified. In fact, on this particular type of policy, the beneficiary might receive considerably more than $5,000, for its value increases rapidly after the insured reaches age 53; at maturity (age 65), such a policy would be worth around $9,000 in benefit payments.

Not all nurses are as mindful of



the future as Mrs. W. True, most of them are now covered by Social Security; yet few can count on anything else. According to a recent study by the ANA, only one out of four of all the general duty nurses in non-federal general hospitals is covered by an employer's retirement plan; and those on private duty obviously have no such protection whatever. Moreover, the ANA survey showed that even where retirement plans are provided, the entire cost of insurance premiums must be borne by the nurses themselves in nearly four out of every ten cases.

To do her best work, a nurse should have the peace of mind which comes with the knowledge that her economic affairs are in good order. The question is—how can she plan her finances so that her present needs and her future security will both be wisely considered under a proposed plan?

A savings account has a primary importance for many because it makes ready cash available for emergencies. It can also be a help in attaining a specific goal, such as the down payment on a home. Another good way to save is by the purchase of government bonds, which yield a slightly higher rate of interest, and, like a savings account, represent liquid assets. Investment counsellors say that the average family, or the average individual, should be prepared for emergencies with liquid savings equal to two or three months' income.

Generally speaking, the popular forms of investment (such as the purchase of stocks or real estate) should not be considered in planning a long-range financial program until after one's savings and life insurance are provided for. Most people rely on such insurance as a basic form of thrift. Four out of every five families now carry it as their major financial resource.

Life insurance has come a long way since the days when it was used chiefly to cover burial expenses. People use it today to provide economic

by Bruce Fouché

protection for their dependents—to guarantee that the family will not be deprived of income, nor the children be denied a college education, if the bread-winner suddenly dies. Some even use it to cover a debt that is incurred or to pay off a mortgage on the home.

But life insurance can also be a source of income for those who live to retirement age (and an ever-increasing number now live well beyond that age.). Most of today's policies build "cash values" for the holders; and these values can be converted into a life income which the retired worker cannot outlive. Only life insurance and annuities offer such security. (Annuities provide life-long income, but usually benefit the annuity-holder only.)

To illustrate the flexibility of life insurance, let us consider the case of a young working mother with a dependent child and earning a modest income.

Sarah B., 27 and a widow, is the clinic registrar at a large city hospital. She earns $2,160 a year plus meals, and is covered by Social Security. She and her small daughter make their home with Mrs. B's sister. As financial protection for the child, Mrs. B. owns a $6,000 "family income" policy. Should she die, this policy would pay her sister $60 a month to care for the child until the latter reaches age 20—whereupon the daughter would receive the full $6,000 benefit. Mrs. B's yearly premium cost, figured from age 25, is about $150.

Should she live to retirement age,

Science Shorts

A preliminary report in *The Journal of the American Dental Association* (September, 1955), describes a refrigerating device that may eventually be used for patients unable to tolerate local anesthetics. The machine, a mobile cabinet housing a refrigerant unit and a heating element, directs a stream of air at the mouth tissues. The temperature of the stream is gradually reduced from 98 degrees to 33.8 degrees, thus anesthetizing the tissues.

■

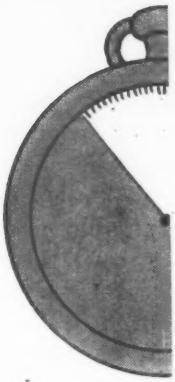
Since the Federal Food, Drug, and Cosmetic Act went into effect in 1938, 10,000 *new drug applications have been filed. FDA's Commissioner reports that more than half of the drugs used today were unknown seventeen years ago.*

■

A Rauwolfia derivative, alseroxylon (Rauwiloid), is of value in treating itchy skin diseases originating wholly or partly in the mind, state two Michigan physicians, Dr. Richard J. Ferrara and Dr. Hermann Pinkus, in the *Archives of Dermatology* (July, 1955). All of thirty-six patients included in a study conducted by the doctors experienced "varying degrees of relaxation, tranquilization, and mild sedation."

■

American Hospital Association statistics indicate that there were more hospital patients in 1954 *than ever before. In* 1954, *there were* 20,345,431 *persons hospitalized—an increase of* 161,604 *over* 1953*'s total.*



Mrs. B. would receive $20 a month for life; or, if she preferred, she could get $34 a month for ten years. Thus, though the policy is intended primarily for the child's protection, it is also a good start toward a retirement fund to help supplement her Social Security benefits. If she remarries, the policy could be made an integral part of the family's financial program.

Suppose you have a dependent mother or father and a limited amount to spend on insurance. You can give your parent maximum financial protection, and still save something toward your own old age by owning a "straight life" policy—which has the lowest premium rate of any lifetime insurance. Here the premiums continue for life, but so does the protection—and such a policy gradually builds cash values over the years which are payable to you later on in old age.

A "limited payment" policy, which can be paid for in its entirety in a certain specified number of years, also provides protection for a dependent; and its cash values increase at a faster rate than those of a straight-life policy. How this kind of policy works is illustrated in the following example:

Elizabeth R., head nurse in the busy office of an eminent physician, earns $100 a week. Her widowed mother is a semi-invalid with a small pension. Five years ago, when Elizabeth's salary was much less, she bought a $5,000 20-payment life policy; its cost, based on age 25, is $145 yearly. If she died now, her mother

Studies involving the use of the synthetic male hormone, stanolone, show that body tissues in old age respond constructively to synthetic hormones. In these studies of elderly men, reported by Dr. Nathan Shock of the USPHS National Heart Institute, a change for the better in personality traits was also noted. But Dr. Shock warns against over-optimism, and states that the ideal steroid-hormone for elderly people is not yet available.

■

There is little chance of patients with drug-resistant TB bacilli transmitting tuberculosis, according to two independent clinical studies appearing in the* American Review of Tuberculosis and Pulmonary Diseases *(August, 1955).

■

A new therapeutic use for morphine in halting chills and reducing fever has been discovered by Dr. Walter E. Marchand of the Bedford, Mass., Veterans Hospital. In a scientific paper, Dr. Marchand observes that morphine never failed in combating chills in a series of 86 patients with severe burns, 14 with transfusion reactions, 9 with soft-tissue infections, 3 with pneumonia, and 3 with typhoid vaccination reactions.

■

Topical administration of Achromycin tetracycline cured 75 per cent of 205 cases of trachoma, states a report of three Japanese physicians in* Antibiotic Medicine *(April, 1955). Relapses were reported as uncommon.

would receive $23 a month. This policy is also building funds for Elizabeth's retirement; beginning at age 65, it will pay her $20 a month for the rest of her life.

Recently, when her salary was raised to $100 a week, Elizabeth also bought an $8,000 retirement income policy—which would give her mother additional life income in the event of the nurse's death. Also, it will pay Elizabeth $80 a month for life when she reaches age 65. The second policy, bought at age 30, costs $335 a year. Thus, for a total outlay of $480 a year, she is assured of a retirement income of $100 a month—which together with Social Security benefits of about $108 a month—adds up to an adequate, livable income for her old age.

"Term insurance" likewise offers protection for dependents, but the coverage is limited to a short, specified period—usually two to five years—and it may or may not be renewable. Policies in this category build little or nothing in the way of policyholder values—which is one reason why the premiums are relatively low.

Where protection for dependents isn't needed, annuities, which are also sold by life insurance companies, provide a good means of saving for retirement. An annuity can either be bought outright by a lump-sum payment or by annual payments. A yearly outlay of $375 a year, for example, would assure a 30-year-old nurse of an income of $100 a month at age 65; if the declared dividends were left to accumulate interest over the years, the monthly annuity payments of the policyholder would increase.

An individual's insurance needs are rarely met through a single policy; each person's circumstances are peculiarly his own. It is wise, therefore, to seek the advice of a life insurance agent whose training and experience can be of real service in making a policy most useful. He can suggest, for example, that a nurse's policy carry a clause waiving premiums during any protracted period of illness.

Major points to consider in discussing your insurance needs with an agent are these: (1) How much insurance, and what kind, do you already carry? (2) Do you have a savings account? (3) Do you own any stocks, bonds, or real estate? (4) Are you covered by Social Security and/or a retirement plan? (5) How many present dependents do you have? (6) To what extent do you wish to protect each dependent in the event of your death? (7) Have you any *potential* dependents—persons to whose support you may find you have to contribute to later on in life?

Remember, the younger you are when you buy a life insurance policy, the less its yearly premiums will be. And remember, too, that it's easier to set aside a little every year, either through insurance or a savings account, than it will be to spare a larger sum later on; and meanwhile your money will be growing in value through the accumulation of compound interest.

CANDID COMMENTS: by Jane M. Hester

Nursing's Abundant Challenges

■ "WITH HINDSIGHT we see that our early enthusiasm over the discoveries of science and our conquest of the air blinded us to natural laws which govern the conduct of men . . . In emphasizing force, efficiency and speed, are we losing a humility, simplicity and tranquility without which we cannot indefinitely hold our own?"

These words, spoken by Col. Charles A. Lindbergh before the Institute of Aeronautical Sciences, might well be pondered by the members of all professions, especially the "helping" ones. Our present preoccupation with the distinctions of science, and our increasing dependence upon its tools, are a growing threat to the natural instincts within us. We can lose, or maim, some of the very qualities that brought the profession into being—and thus go off-course in our aims.

When I was a young nurse working with doctors of the old school, we taxed our strength, ingenuity, and imagination to save a life. "Never give up, *never*, even to the last sip of water," Dr. Pelton would say when the battle seemed about lost. It made no difference whose life we fought for—our challenge was a life entrusted to us. There grew within us then an abiding reverence for life that deepened with the years. Like the young Lindbergh in 1927, flying the Atlantic alone in a pioneer crossing, we had to draw heavily on our inner powers, for the tools of modern science were not yet fashioned.

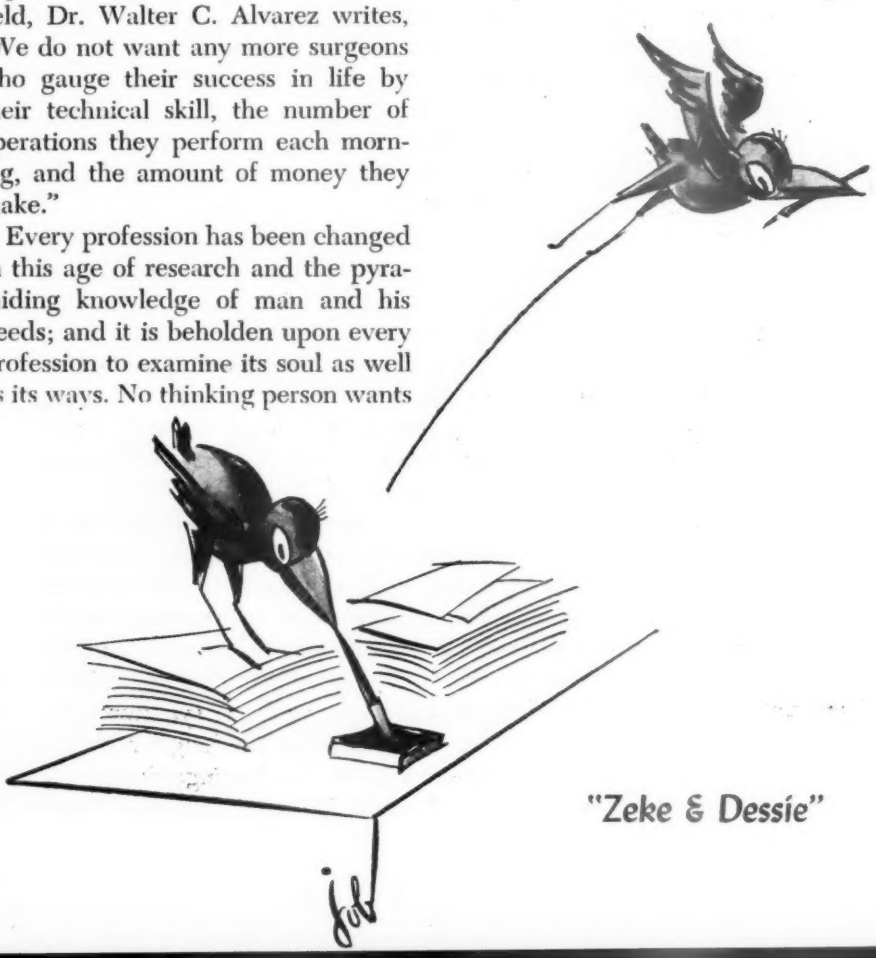
Today the tasks that called for much of this devotion and effort have been transferred to the precise instruments and medications of science. What else have we transferred? Not long ago I asked a doctor if something more couldn't be done to save an old friend in extremis. "We've made all the tests, given the indicated antibiotics; what more can we do?" was the reply. The autopsy revealed a condition that might have been detected by the skilled observation and study of symptoms. In this period of transferal we must be vividly alert to the danger of transferring our birthright, too—the special powers that distinguish us as a profession. In nursing, too, we can become "blinded to natural laws

which govern the conduct of men."

Outstanding leaders in a variety of professions are aware of the perils of changing the *focus* of our efforts, along with changing our methods. My folder, "Science versus the Art," is fat with trenchant articles on the subject. Our eighteenth century education was "unquestionably the most civilized this country has ever known," writes Edgar Ansel Mowrer. It freed the individual to develop his highest powers. But our twentieth century educators and intellectuals, impressed by mass production methods, have "surrendered to the forces making for depersonalization." In the medical field, Dr. Walter C. Alvarez writes, "We do not want any more surgeons who gauge their success in life by their technical skill, the number of operations they perform each morning, and the amount of money they make."

Every profession has been changed in this age of research and the pyramiding knowledge of man and his needs; and it is beholden upon every profession to examine its soul as well as its ways. No thinking person wants to go back to pre-scientific days, but every thinking person knows that science has strict limitations. It cannot replace the human qualities that must always fire and direct the machines. *The science must be practiced through the art*—anything less deviates from our reason for being.

Nursing cannot escape the perils that come with momentous change, not only in education and practices but, more important, in spirit and philosophy. We must ask ourselves: Have we become so engrossed in our pursuit of efficiency, skills, degrees, professional prestige, and the machinery of associations that our spirit



"Zeke & Dessie"

of adventure in human welfare has been overshadowed? Have we helped create conditions that make nursing a chore instead of a challenge? Are we pushing fact-learning and conformity at the expense of the pioneering that develops the spiritual as well as mental powers of the individual?

It is the nature of our yearnings that marks the character of our efforts. "Lead me to the rock that is higher than I," prayed the Psalmist. What are the things *we* are reaching for? For greater personal prestige or greater professional service? Is reverence for life still the dominating force for all of us? What do we want

the profession to make of the nurse?

The single-handed nursing of the past doesn't fit today, even in private duty where three nurses now share the responsibility of one patient. Today's patient care demands a more scientific and mature approach through the group work of a variety of people, from the doctor to the orderly. It has brought gains in effectiveness, but also losses in satisfaction. What thought are we giving to these losses? When I hear of callous, irresponsible, selfish nurses I cannot forget one thing. They must have had within them some power for good when they decided to enter nursing. What, then, brought out their worst?

The moving ideals of a growing generation are not usually acquired in book study or through lectures. They are rubbed off from their elders, their teachers, those about them who make the rules and set the course. Unwittingly, in everything we do we reveal our attitudes, our ambitions, our philosophy. Young people are shrewd; they are quick to learn if we practice what we preach. I often wonder if our heavy losses in young graduates aren't due to more than early marriages. It could be that some of these young people failed to find the spiritual satisfactions they had come to expect. The good life must tie in with something greater than self; something much more stirring and vital than the outward evidences of progress, such as degrees, status, and salary—all visible rewards.

I cannot believe that the basic aims of nursing have changed, but I do believe there has been a shift of emphasis in what we think is important in achieving these aims. We concentrate thought and attention on *nurses and nursing* rather than on *nursing and the patient.* It is a subtle distinction that requires considerable pondering. Preparation, division of duties between the various groups giving care, and rewards—all these fill our minds. Function studies are primarily research in efficient administration rather than in patient needs—and patient needs have diversified and expanded widely in the changed and changing scene. We study processes, not patients.

The same stress seems evident in nursing education. The emphasis seems to be heavily on the establishment of professional status, and on learning new facts and skills—not primarily on the kinds and quantity of nursing care which today's patients need. In all areas we seem to have shifted our points of emphasis. For example, I quote from the letter of a public health nurse: "Our old supervisor would go out with us to a problem situation at the drop of a hat. With her, a family crisis took precedence over all else. Our new supervisor is so busy with committees, conferences, luncheons, and such that we have to make appointments to see her."

We used to hear much criticism of nurses because when they came together they talked mainly about "my patient." The pendulum has swung widely. I've come away from some meetings wondering, almost bitterly, if the patient hadn't died of exposure [*Continued on page* 86]

IDEA OF THE MONTH

What's the matter with us?

by Helen Murphy Donovan

■ IT'S PRETTY DISTRESSING to ponder the predicament in which hospital nursing finds itself today. Many of us in the profession are dissatisfied with the kind of care being given. Doctors, too, are frequently dissatisfied; and countless complaints are leveled against us by patients, their relatives, and the general public. What's the matter with us?

In attempting to answer this question, I'm going to take a new point of view. Part of it is this: Each and every one of us should begin with the frank admission that her own contribution to nursing care is far from perfect. This is painful to do, for we are all reluctant to explode our illusions about our own individual competence. It is much easier to criticize the shortcomings of others than to come to grips with our own. Thus, directors of nursing want to change the performance of staff nurses; staff nurses want to change the directors' responsibilities; and around it goes.

It is my belief, therefore, that we must first penetrate this endless circle of "buck-passing" by an honest effort at soul-searching; we must all admit guilt (and I do mean guilt) for the dilemma in which the profession now finds itself.

The other part of my viewpoint is this: If we are to solve our problems, we must analyze and explore them deeply, and discuss them openly and frankly. This, too, is painful, for it takes time, energy, and patience. It is much easier to evade the issues.

Now let us look at a nursing staff. Do we resemble any of the following nurses?

The director of nursing is so busy with desk work and so beset by "the shortage" that she seldom finds time to make rounds or to sit quietly and figure out ways to remedy the alleged shortage. The assistant director makes day-to-day staff changes without consulting the supervisors; she does make rounds occasionally, only to find that some supervisor has beaten her to it by half an hour. This supervisor, in turn, seldom finds time to tear herself away from her desk; so, if Ward B is having a hectic hour when she finally makes her rounds, she either tactfully excuses herself and beats a hasty retreat (for fear of getting involved), or she interrupts everything by asking the head nurse

about the weekly requisitions. The head nurse is occupied in the checking of supplies, making out time sheets, and cleaning equipment. The younger staff nurse passes medicines, gives treatments, and makes endless entries on charts. The older staff nurse complains that no one smooths the patient's pillow nowadays, and that practical nurses are usurping the professional's job. The recent graduate complains that the older nurses are afraid to tackle such a procedure as the care of a closed chest drainage. In other words, each of us criticizes someone else for something or other as our paths cross.

Underlying all such situations are two fundamental deficiencies: (1) ignorance of nursing care itself, and (2) ignorance of its proper administration. Yes, *ignorance* is at the heart of our trouble.

Clinical competence and administrative ability are demanded of all professional nurses in hospital service. True, more is expected of the director than of the staff nurse; but each must possess these qualities in a degree equal to her responsibility.

Yet how many of us view nursing in its totality? Don't most nurses believe that it consists of physical care and carrying out doctors' orders? Let's examine our collective conscience on a few specific points:

In turning the acute cardiac, are we sure that we don't expend his energy? When we check the woman who is being wheeled away to the O.R., do we wonder whether she would be helped if we accompanied her? Do we know the signs of response in the patient who has had neurosurgery? Have we bathed the face, hands, and back of that perspiring oldster? Have we done anything about procuring free dressings from the local chapter of the American Cancer Society for that terminal patient? Have we made certain the diabetic can administer his own insulin when he gets home? Have we changed that nasal catheter supplying needed oxygen? Have we observed and recorded the fact that the epileptic's symptoms are absent today for the first time since his admission? Have we suctioned that elderly patient's tracheotomy tube without changing our facial expression? Are we watching constantly for signs of bleeding in the patient who's receiving anticoagulant therapy? Have we done anything about the man who is listed as having no religion yet has a rosary in his drawer?

On and on we could go, asking ourselves such questions. Most of us, I repeat, are merely bathing and feeding patients and carrying out doctors' orders. This is our concept of nursing. We are woefully inadequate in the matter of total care—by which I mean physical, emotional, social, and spiritual care. Until we are willing to admit this inadequacy, we will continue to criticize our colleagues instead of upgrading the quality of the service for which we are personally responsible.

Those of us on all administrative levels could also profit by a similar self-examination of conscience. For example:

Are we functioning on a day-to-

day basis, with little or no thought given to the long-range improvement of nursing care? Do we have a clear-cut aim for the nursing department, or even a vague aim? How many people under us have more than one boss? Is each one evaluated by her immediate superior? Are administrative policies in writing and available to all? Is our professional coverage concentrated on the day shift? Is any provision made for counseling and orienting newcomers? Are all facts assembled before decisions are made? Do we acquaint the medical staff with our objectives and difficulties? Do we understand the ratio of professional to non-professional workers in terms of nurse conservation, safety of care, and cost to the patients?

Here again we could go on and on with the questions—and each would make it more and more evident how inadequate we are in our understanding of the administrative process. Many—if, indeed, not most—of us are applying standards of a generation ago to a service which since has been deeply penetrated by phenomenal changes. Meanwhile the hospital field has become the nation's sixth largest business—and we are operating its largest service with obsolete and inadequate methods of personnel administration.

To sum up: I believe that we must—personally and collectively—direct our energies to the task of identifying, analyzing, and correcting our own shortcomings, instead of dissipating these energies in fruitless and unnecessary recriminations.

". . . but the greatest of these is charity"

● THE ADMITTING OFFICE of a private hospital in Detroit was thrown into something of a panic one day not long ago by the sudden appearance of a highly excited and shabby-looking Mexican couple. The wife, about to give birth, had to be rushed off to the emergency room before anyone could even obtain her name and address—and the husband was obviously so nervous that he couldn't be questioned, either. There was nothing to do but let him pace the floor and bite his fingernails—at least for the present.

Some time later, when a nurse came in to inform him that he was the father of an eight-pound boy, the man calmed down a bit—but he was still plainly worried about something. "My wife and I are very poor," he told the nurse. "I'm out of a job and we're on relief. I can't possibly pay the bill now, unless—"

He stopped short as a bright idea suddenly flashed into his mind. "Does the hospital have a contract with the Welfare Department?" he asked.

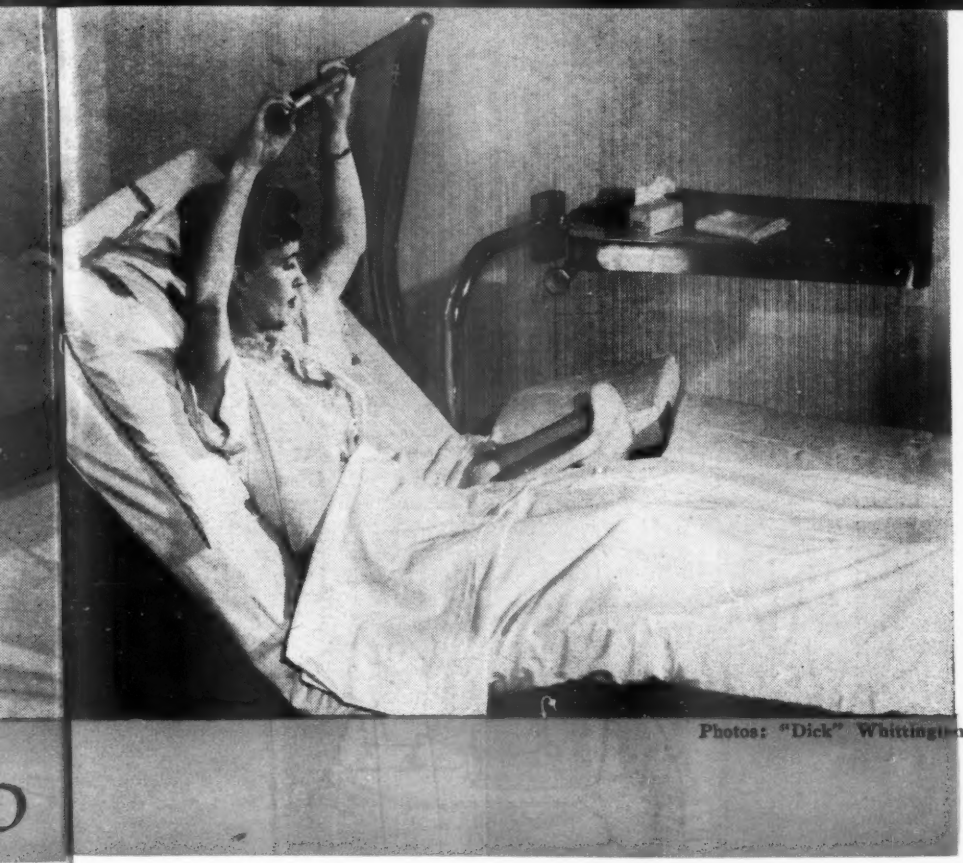
"I'm afraid not," replied the nurse with a smile. "This is a private hospital. But we do have a contract with the Lord!"

—JAMES SCALES

COMES NOW THE BEEM BED

■ **THE PUSH-BUTTON AGE may soon make its influence felt in the world of bedside nursing. Already in factory production is an ingenious new hospital item known as the Beem Bed—a completely mechanized affair estimated to save 46 per cent of a nurse's time and claimed by its promoters to be "the biggest news in patient care since Florence Nightingale."**

Named for its surgeon-inventor, Dr. Marvel Beem of Los Angeles, this streamlined "dream bed" features numerous innovations, foremost of which are its built-in bathroom facilities: a sewer-connected flush toilet and a gleaming porcelain lavatory with hot and cold running water. These retractable facilities, concealed beneath the bed when not in use, become available within a few seconds by means of push-buttons which the patient can easily operate. Furthermore, a readily reached retractable trapeze Bar enables the patient to change position without the aid of an



Photos: "Dick" Whittington

attendant—a notable feature in these days of nurse shortages.

Other push-button features, operable by the nurse, include: (1) variable elevation of the bed between 23-inch and 32-inch heights; (2) mechanized positioning for Trendelenburg, reverse Trendelenburg, and Fowler-Trendelenburg positions; (3) an automatic, timer-controlled oscillator; (4) a self-contained, detachable hospital cart, which enables an attendant to transport the patient without assistance; and (5) built-in scales for weighing the bedfast patient.

The bed has been hospital-tested and the first permanent installation made at Stanford University Hospital in San Francisco. More than ten years' work and a third of a million dollars are reported to have gone into its development. But how it will affect hospital costs and the shortage of bedside nurses remains to be seen. [Plumbers, maybe, we'll need more of?]


1.
2.
3.

Negative reaction!

A message of hope

by Francelia Butler

In the January, 1952 issue of R.N., there appeared an article on the Cured Cancer Club of Washington, D.C. Readers will be interested to learn that this unique organization is still flourishing, bringing aid and comfort to hundreds of patients who may be temporarily daunted and seriously depressed by one of the so-called dread diseases.

■ THE CURED Cancer Club in Washington, D.C., is dedicated to helping nurses help their cancer patients. Members of this Club are well equipped to do this, for all sixty or so of them have had to face the diagnosis of cancer at some point in their lives. Not all members feel that they have necessarily been "cured" of cancer, even though they have lived five years without recurrence of the disease. But all are convinced that their lives have been greatly prolonged and made useful by modern treatment methods.

One of the active members of the Club is Gertrude Andrews, R.N. Gertrude was an attractive, unmarried woman of thirty-nine when she learned that she must have a breast removed because of cancer. "I am not an emotional person," she says now, "but it hit me terribly hard. As a nurse, I had comforted other cancer patients, but I didn't know the psychological impact of cancer until it happened to me."

A couple of years ago, at the age of forty-three, Gertrude was married for the first time. She met her handsome husband, Raymond L. Johnson, after her operation. Mrs. Johnson is now an x-ray technician at a world-famous hospital in the Washington area, where she gives cancer patients the sympathetic care which only an ex-patient can give.

Like other members of the Club, Gertrude does not particularly enjoy the publicity of offering herself as living proof that cancer can be cured or that, at least, it does not spell the end of a professional or normal life. She believes, however—especially where other nurses are concerned—that it is her duty to give that reassurance and hope which she can give best, not only for their sake, but for the sake of

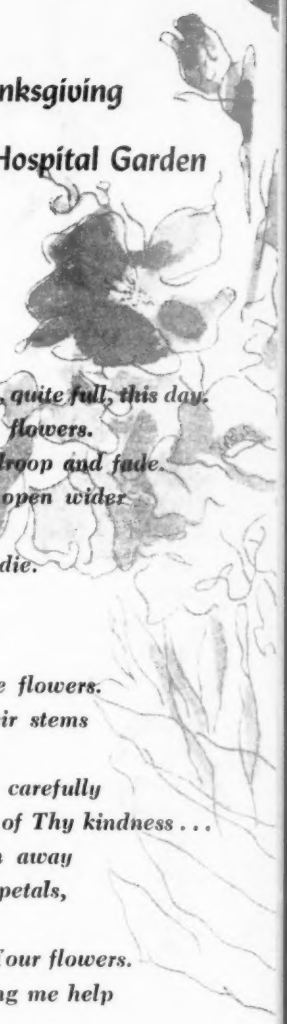
their patients who are in need of it.

Material as well as moral help is also provided by the Cured Cancer Club, which maintains a well-stocked Gift and Loan Closet for the benefit of cancer patients in the Washington area. The Visiting Nurse Association of Washington often calls on the Club for such equipment as food blenders, trapezes, walkers, pneumatic mattresses, aspirators, hospital beds, wheel chairs, bed pans, and rubber rings. The help is reciprocal, too, for the All States Nurses Association, a local association composed of out-of-town nurses in private practice, has presented the Club with a hospital bed. Thus, nurses help the Club, and the Club, in turn, helps the nurses with morale-building cards and visits.

Club members have taken part in nurses' symposia, particularly those sponsored by the Graduate Nurses Association of Washington, D.C. The president of the Cured Cancer Club, Priscilla Kern, talked at one of these meetings. Mrs. Kern had two operations for intestinal cancer ten years ago. Nothing, not even the further recent complications of diabetes and a broken hip, has deterred her from her work of visiting sick cancer patients, comforting those who are lonely, and getting Club members, in so far as they are able, to meet the emotional and material needs of patients.

Letters addressed to the Club pour into Washington by the hundreds. Some of these are from well-known people. Others are from "just people" all over the world. These letters are channeled to Club members who have success- [*Continued on page* 90]

A *Prayer of Thanksgiving in a Hospital Garden*



Great Gardener,

I have both arms full, quite full, this day.
With small bruised flowers.
Some of them will droop and fade.
Some of them will open wider
to face the sun.
Some of them will die.

Dear Gardener . . .

I know You do love flowers.
Help me to cut their stems
with gentleness.
Let me place them carefully
in the cool water of Thy kindness . . .
And if I must trim away
dead leaves and petals,
Teach me to do it
without injuring Your flowers.
Thank You for letting me help
in Your work,

O Wise Gardener.

Thank You for appreciating
the beauty of those
You have placed in my care today.
See, I have both arms full, quite full,
with small bruised flowers.

—LOIS ROWE, R.N.

News in Review

▶ BY DOWN-GRADING the rank of head nurse to that of general duty nurse, and of supervisory nurse to that of head nurse, without changing in any way the duties of those involved, New York City's Department of Personnel recently attempted to nullify the effects of a substantial pay boost granted last June to some 1,300 such R.N.'s employed in municipal hospitals. The nurses' objections, upheld by the New York State Nurses Association, resulted early last month in a victory for those in the supervisory category, but with the claims of the other group subject to the qualifying provision of an on-the-job survey.

▶ U.S. DRUG ADDICTS, now estimated to number 60,000, spend a daily average of $10 each on narcotics, according to Federal officials. New York State, with 9,458 known addicts, heads the list, followed by Illinois with 7,172 and California with 2,350. Half the total—50.3 per cent—are said to be in the 21 to 30 age group; 13.1 per cent are under 21; and 36.6 per cent are over 31. Heroin, worth about $60 an ounce in Hong Kong, is being illicitly peddled here in one-grain "bindles" for as much as $8,750 an ounce, these sources say. A proposal by the New York Academy of Medicine, aimed at taking the profit out of the drug traffic by making free or low-cost narcotics available to addicts through outpatient clinics, met with both favorable comment and harsh criticism at public hearings conducted recently by a Senate subcommittee which is making a nationwide study of the narcotics problem. Another reappraisal of the problem is reportedly planned by the AMA cooperating with the American Bar Association.

▶ FIRST MALE R.N. to be commissioned in the Army Nurse Corps is Lt. Edward L. T. Lyon of Kings Park, N.Y. Inducted as a private in September, Lt. Lyon was discharged as an enlisted man on October 5, the day before he was sworn in as an officer at a special commissioning ceremony at Governors Island, N.Y. Lt. Lyon applied for the commission under the provisions of the recently-adopted Bolton Amendment. Some 80 men nurses in the Army are now eligible for commissions under the new law. A graduate of Kings Park

U.S. Army Signal Corps

Lt. Lyon's mother, Mrs. Barbara Lyon, and First Army Surgeon, Brigadier General Harold W. Glattly, pin on the gold bars.

School of Nursing and the University of Pennsylvania School of Anesthesiology, the 25-year-old lieutenant served as anesthetist at Nassau Hospital, Mineola, N.Y., before his Army induction. He is a member of the American Association of Nurse Anesthetists and the New York State Association of Anesthetists. His new Army assignment is a basic nursing course at Fort Sam Houston, Tex.

▶ALBERTA, CANADA sources have reported that the nurse shortage there has been eased considerably in past months. Many married nurses have returned to active duty in urban hospitals, it is said. Rural areas, however, are still finding it difficult to keep hospitals adequately staffed.

▶THREE FELLOWSHIPS for postgraduate training in research methods were awarded to nurses last month by the Public Health Service, whose 1955-56 budget includes a Congressional appropriation of $625,000 for a new program aimed at improving the quality and availability of nursing care through scientific investigation. Further fellowships as well as research grants are available to R.N.'s who can meet PHS requirements. For details, address the Division of Research Grants, National Institutes of Health, Bethesda 14, Md.

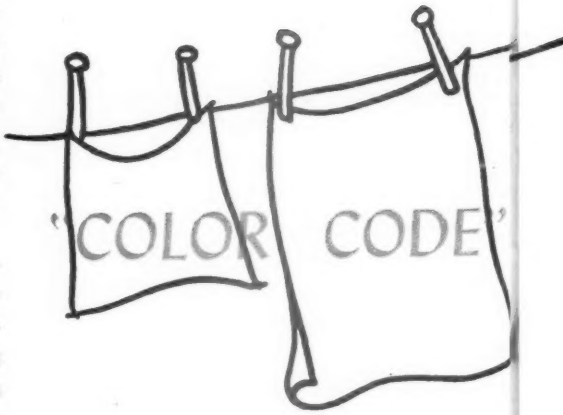
▶LOUISIANA'S first state-supported school for the training of Negro nurses, now under construction at Charity Hospital, Lafayette, La., will offer courses leading to a B.S. degree [*Continued on page* 92]

About People: ***Mlle. Genevieve de Galard-Terraube,*** **heroine of the siege of Dienbienphu in Indochina, has begun a ten-month training course in the care of the physically handicapped at New York University-Bellevue Medical Center in Manhattan . . .** ***Dorothy McMullan*** **has been appointed director of Russell Sage College School of Nursing, Troy, N.Y. . . .** ***Mrs. Mary H. Lindenberg,*** **executive director of Denver's VNA and the first nurse to be employed by the Colorado health department, retired recently after thirty years of public health nursing . . .** ***Hulda O. Wegener*** **is the chief executive officer of the Kansas SNA, succeeding** ***Irma Law,*** **who has retired . . .** ***Francis Cuda,*** **director of nursing at the Amsterdam (N.Y.) Hospital, has been made its acting director . . .** ***Joan Beston,*** **a 24-year-old nurse at Morristown (N.J.) Memorial Hospital, was awarded a gold medal of valor by the New Jersey Patrolmen's Benevolent Association for saving an 11-year-old girl from drowning . . .** ***Annabel B. Reid*** **of Phoenix, Ariz., has been commissioned a senior assistant nurse officer in the Public Health Service . . .** ***Ann Webster,*** **a Canadian Eskimo employed as a public health nurse in the Far North, is reportedly the first member of her race to become an R.N. . . .** ***Capt. Gloria Sauls,*** **AFNC, was named "Miss Air Force of 1955" . . .** ***Louisa E. Perritt,*** **80, a retired public health nurse of Arkadelphia, Ark., is credited with having raised the health standards in her county over a period of twenty-six years "to a height that is surprising even to health officials"...** ***Marguerite Lampirez,*** **president of the National Student Nurses Association and senior at Northwestern State College School of Nursing, Natchitoches, La., flew to New York recently as a guest of** ***Glamour,*** **a popular national publication.**

■ SIX YEARS AGO, Salem (Mass.) Hospital was beset by a mounting inventory loss on its linen supply. In a single four-months' period, a total of 7,324 items—mainly sheets, towels, face cloths, and diapers—had "vanished" from the linen inventory through laundering, theft, misuse, and an inadequate method of distribution. Three years later, after the 303-bed hospital had revamped its inventory control and devised a "color-code" system for permanently marking each item, the annual loss of linen had been cut by more than 80 per cent.

For many years, Salem's linen distribution had been handled by the familiar requisitioning method commonly used in hospitals. Under this system, each charge nurse orders her needs directly from the laundry or central linen room by means of a written requisition—a form usually subject to approval by the nursing director or her assistant. At Salem, it was discovered that this system had a serious flaw: No floor kept any linen on hand, and charge nurses, ordering their daily needs eight to twenty-four hours in advance, often found it difficult to make accurate estimates on certain items.

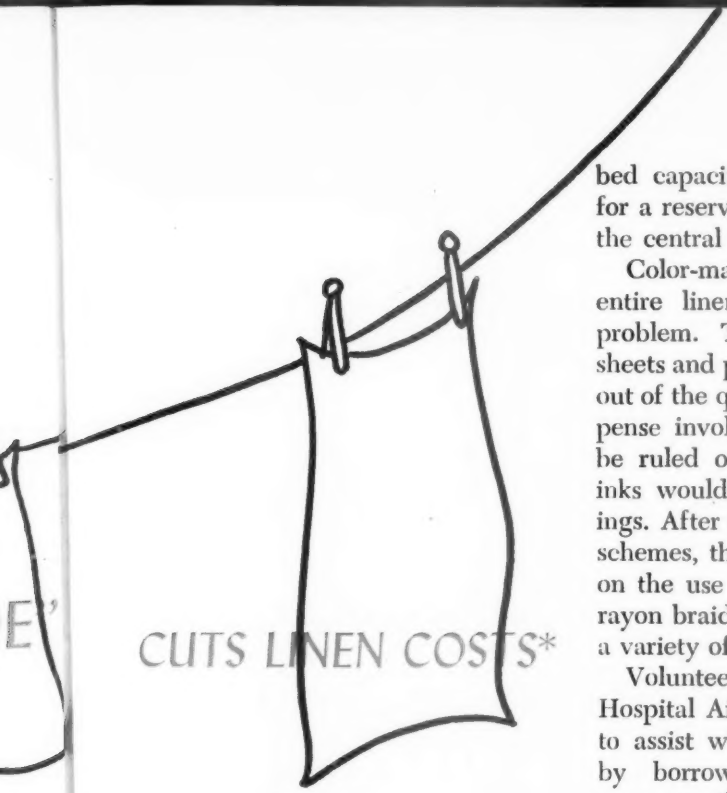
Other methods of distribution were considered by the hospital's linen control committee, a board comprised of the director of nursing, her assistant director, and the laundry manager. After conferring with the administrator of the hospital, the committee decided to do away with the requisitions and substitute a system



of "direct exchange" of all laundry.

Under this system as it operates in other hospitals, each floor has its own pre-determined quota of sheets, towels, gowns, etc. When a floor sends its soiled linen to the laundry, it supplies the laundry with a count on each item. This count is checked by a laundry worker, and a supply of fresh linen, equal to the number of soiled items, is issued to the floor. But the fact that the floor tally and the laundry tally frequently fail to jibe leads to difficulties: charge nurses contend that the laundry is "short-changing" them, while the laundry constantly suspects the floor people of purposely padding their linen count.

Forseeing this weakness in the sys-



CUTS LINEN COSTS*

tem, the Salem committee took steps to circumvent it in adopting the direct exchange method. By establishing a "color code" which would give each floor's linen a distinctive color mark, the exchange of items between floor and laundry could be greatly facilitated, the committee felt.

Also foreseen was the need each floor would have for a reserve supply of linen in addition to its pre-determined quota of regularly used items. So, in setting up each unit's quota (which, naturally, was based on its bed capacity), provision was made for a reserve allotment to be held in the central linen room.

Color-marking of the hospital's entire linen supply was no small problem. The use of vari-colored sheets and pillow cases was obviously out of the question because of the expense involved. Ink-marking had to be ruled out because most colored inks would fade after a few washings. After considering various other schemes, the committee decided upon the use of a sewed-on, fast-color rayon braid which was obtainable in a variety of distinctive shades.

Volunteer members of the Salem Hospital Aid Association were asked to assist with the tabbing job; and by borrowing or commandeering every available sewing machine in town, these women were able to attach strips of colored braid to 13,000 items in five days.

Once the new system had been put into effect, everyone on the staff seemed suddenly to become linen-conscious. Charge nurses, because they had had a hand in setting up their own quotas, carefully supervised the distribution of their bed linen. Hoarders were no longer able to over-order as they had been doing. In the laundry and linen room, paper work had been practically eliminated. And losses by theft were unquestionably reduced—as they always are when a new system of control is introduced.

Yet something was still needed to give the new system its full potential of control: [*Continued on page* 98]

*A condensed version of an article by Edwin T. Cullen, originally published in *Hospitals*, Journal of the American Hospital Association, 29:106, August 1955. Permission to reprint the facts has kindly been granted by the publisher and the author. The latter, laundry director of the Salem Hospital, is first vice-president of the National Association of Institutional Laundry Managers.

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Editorial

[*Continued from page* 35]

administrator going to be when he tries to fit them into a given algebraic equation?

As experienced as the panel members are in their respective fields of research, they are still expert, not omniscient. Therefore, despite their cautioning voice of adapting this ratio to local conditions, they provided a sought-after statistical measure, and it is human nature to use as absolutes yardsticks which are meant as guides, and to condemn them when they prove to be guides only, not panaceas.

And speaking of panaceas, if the adjoining room had not been separated, the panel and audience in Room 13 could have heard their counterparts in the next room offering their own panacea to the hospital staffing problem—the practical nurse. The administrators in Room 14 needed no statistical crutches; they knew that hospital economics was such that they could remain financially sound if they paid practical nurses two-thirds of the professional nurse's salary and hired aides in a lower salary bracket to relieve the practical nurse of numerous, routine tasks.

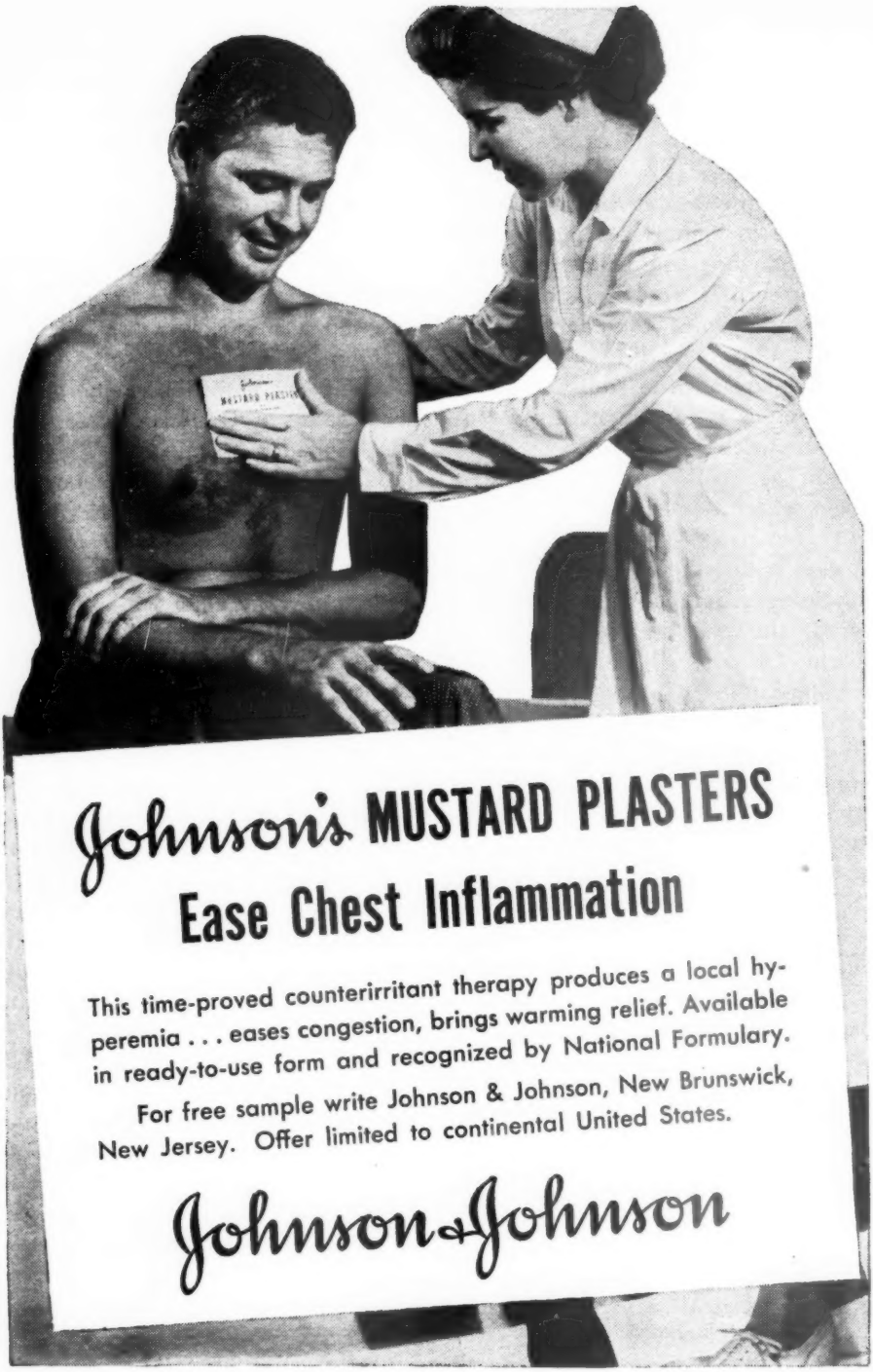
There was no talk, as in Room 13, of utilizing the professional nurse where she is most needed—of taking away clerical, housekeeping, and lesser duties, so that she can return to the bedside to do actual patient care. In Room 14, they were promoting practical nurses to head nurses' positions, but coining the title, Senior Practical Nurse, so as not to upset professional nurses.

However, the discussants in the two rooms had one thing in common —a narrowing of thinking: how few nurses for how little expense. Their ideas were not complicated by thoughts of patients' needs—except in the case of one outstanding member of the audience in Room 13.

After much pulling and tugging by the participants for a definition of what is a professional nurse after she has been stripped of her non-professional duties, Ruth Sleeper, Director, School of Nursing and Nursing Service, Massachusetts General Hospital, sounded the first note of clear, unhypothetical thinking when she said, "It is not a question of who does what, but who does what for what patient."

It is not the listed functions of either professional or non-professional nurses that should be the guide for staffing ratios. Figures are not viable, they are not critical, and they cannot have their hospital stay prolonged because of inadequate or inept nursing care. If patients were inanimate machines, we could, by numerical deductions, set up a formula: X number of nurse-hours x Y number of patients = APC (adequate patient care). But is it not this animate, human quality that makes it impossible to establish a ratio of professional to non-professional nurses without including vital, breathing, dependent, demanding patients?

—Alice R. Clarke, Editor



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American Hospital

[*Continued from page* 38]

standing is reflected in the selective screening of its intern-applicants: only five are selected annually from the thousands of young American doctors who apply for a year's training here. (One intern told me recently that some of Europe's best medical brains are on the staff.)

French labor laws are strict, and a special visa is required to work at the hospital. Moreover, there's a one-year limit on the time you can nurse in France; and you may have to allow six months to get all your papers through the various government bureaus. But once you're accepted by the hospital, the process is automatic.

Here's a run-down of requirements and procedures for those interested in working here:

REQUIREMENTS: (1) under age 30; (2) one year's experience after graduation from training school; (3) registration with a state nurses' association; (4) a knowledge of French—i.e., ability to speak, read, and write it.

PROCEDURE: (1) write a letter of application to Miss E. O'Neil, Directress of Nurses, American Hospital in Paris, 63 Boulevard Victor Hugo, Neuilly-sur-Seine, France; (2) when notified that your application has been accepted, present your credentials and a request for sponsorship to the American Nurses Association; (3) wait for your contract to arrive from Paris; (4) present this contract to the nearest French consulate to obtain your working visa; (5) apply to the U.S. State Department for your passport; (6) book your passage well in advance, especially if it coincides with the May-to-September tourist season. (You must, of course, pay all of your own traveling expenses.)

Nurse-tourists frequently turn up at the American Hospital seeking employment. In some cases, they've run out of funds and hope to recoup their finances by working a while. Unfortunately, the hospital can't offer employment on short notice because of the working-permit requirement, which may involve a six-month wait. This is something to bear in mind.

Also it's well to know that "specialing" in France is more or less out of the question; a definite contract is needed to obtain a working permit, and the touch-and-go aspects of private duty nursing do not lend themselves to contracts.

No stipulation is made by the hospital about bringing along some ready cash, but it's a good idea to provide yourself in advance with a sum well beyond the cost of your round-trip passage. You're likely to need it—for a hop to London, say, or a whirl at Paris shopping. And what could be better, when your year's contract expires, than a sight-seeing tour of Europe? Such a trip would be a fitting climax to your experience in international nursing; it would not only bring you pleasure and cultural enrichment but a better understanding of other people—a much-needed asset in today's chaotic world.

AHA Convention

[*Continued from page* 39]

specialized skills of the practical nurse. One speaker predicted that the practical nurse will eventually take over the R.N.'s duties. [*While nurses are studying their functions, have hospital administrators already determined them?*]

What must have been a most informative meeting for hospital administrators was the round table on the accreditation program of the National League for Nursing. Speakers from schools that had received NLN accreditation visits spoke frankly and in detail of their experience with full and temporary accreditation. The audience was informed by NLN representatives that NLN consultation visits to schools for one day are without charge; a consultation fee is charged for more than a one-day visit. At a delegates' meeting, AHA members were told that some solution would be found for the problems of non-accredited schools. The cut-off date for the temporary accreditation program is January 1, 1958.

Hospital-physician relations—one of the most controversial convention topics—were aired at the last general session from the viewpoint of the public, the physician, the hospital, and legal representatives. While agreeing that hospital-doctor squabbles should be settled around a conference table, the speakers could not ignore the fact that professional discord in several states had erupted into legal warfare. Many physicians, it appears, hold that hospitals are unlawfully engaging in the practice of medicine when they hire radiologists, pathologists, and anesthesiologists; what M.D.'s particularly abhor is hospital billing of patients for professional services. When the representative of the public was asked how he would feel about receiving multiple bills from radiologist, pathologist, and anesthesiologist after a hospital stay, he replied: "I'd also have a bill from a psychiatrist." [*If nurses wished to follow the medical specialists' line of argument, mightn't they logically say that hospitals, because of their hiring of nurses, are illegally engaged in the practice of nursing?*]

As in all conventions, AHA or

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otherwise, names made news. This year, Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn., was unanimously voted president-elect. Dr. Snoke will succeed Ray E. Brown, incoming president, at the 1956 convention in Chicago. Among those awarded honorary memberships in the American Hospital Association was Ruth M. Sleeper, past president of the National League for Nursing, and Director, School of Nursing and Nursing Service, Massachusetts General Hospital, Boston, Mass. Honorary memberships in the Association are made on the basis of outstanding contributions to the health and welfare of mankind.

Holding their 22nd annual meeting concurrently with the AHA convention, members of the American Association of Nurse Anesthetists were given solid convention fare of scientific papers interspersed with organizational business. The AANA, which celebrates the 25th anniversary of its founding this coming year, reported progress in accreditation, with 89 out of 106 approved schools of anesthesia fully accredited under its new program. Members were informed of the availability of an insurance program offering personal and professional liability, disability, and retirement insurance. A new by-laws change makes current registration a mandatory prerequisite to annual renewal of membership. Top AANA news, however, was a startling statistical report of an Association survey of who actually is giving anesthesia in hospitals throughout the country. [*A complete review of this study, which is sure to cause a professional stir among nursing and medical groups, is scheduled to appear in a forthcoming issue of* R.N.]

AANA officers include Minnie V. Haas of Fort Worth, Tex., re-elected president; Lillian Baird of Ann Arbor, Mich., re-elected first vice-president; and Olive Berger of Baltimore, Md., re-elected second vice-president. The Association's treasurer is Mrs. Marie McLaughlin of Harvey, Ill. Trustees elected to office in the Association are Mary Costello, Region 1; Charlotte T. Turner, Region 1; Genevieve Reagan, Region 4; and Mrs. Catherine F. Ingraham, Region 5.

—Frances Elder

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Narcotic Problem

[*Continued from page* 49]

individualized psychiatric therapy is pursued. The patient is also kept busy in a program of occupational therapy—to prepare him vocationally for a useful place in society upon his release. Recreational and social activities, as well as group therapy (such as that provided by Addicts Anonymous), are usually recommended.

Unfortunately, even the most modern methods of treatment are followed by a high rate of relapse; permanent cures can be claimed in less than 25 per cent of the cases. The best cure is to prevent addiction in the first place. Consequently, a number of preventive plans have been developed in recent years. Among these are certain educational programs whose aim is to inform the public of the true nature of addiction and alert youngsters, especially, to its serious personal dangers.

Some professional people seem to need this knowledge more than teenagers do. Many in the health field have mistaken beliefs about the addicting properties of the newer synthetic narcotics, such as meperidine and methadone; a number of those addicted to such drugs are doctors, dentists, pharmacists, and nurses. Because the new substances are not natural opium derivatives, professionals frequently fail to handle them cautiously. Not only have these drugs been carelessly prescribed and administered, but in many instances they have been misused in the self-treatment of such minor conditions

When patients ask you about coffee—

As you know, some people can drink ordinary coffee without being affected by the caffein it contains—others can't. So, when a patient asks you if he or she should drink coffee, why not suggest New Extra-Rich Sanka Coffee?

Sanka Coffee, of course, is 97% caffein-free. It can't irritate delicate nerves or cause restless, disturbed sleep. And today's *New* Sanka Coffee, prepared a new way, tastes every bit as good *or better* than the coffee your patient has been drinking!

Try New Extra-Rich Sanka Coffee yourself and see. And see if you, too, don't sleep better at night, feel better during the day!

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as mild headaches and menstrual pain.

Before long, the careless scrounger of an occasional tablet may find himself the victim of a true addiction, with the drug being used to ease emotional rather than physical pain. Since self-medication by the psychoneurotic is rarely successful and always dangerous, the nurse requiring a drug should seek psychiatric help, as there is certainly the danger of addiction.

Nurses' organizations should alert members to the pitfalls of addiction and make them familiar with the provisions of the Harrison Narcotic Act. Nurses should know and follow its strict provisions concerning daily inventories, record-keeping, and disposal of drugs placed in their care. R.N.'s are morally and professionally responsible for the attitudes they convey to nonprofessionals, who can learn much by example. Vigilance and self-discipline, both by individual nurses and special organizational committees, are necessary to avoid personal disaster and adverse publicity that could hurt the whole nursing profession.

The installment buying of health insurance should be as painless as the purchase of a new car, is the opinion of Dr. Odin W. Anderson, research director of the Health Information Foundation. Health services cost the average family $207 annually, he points out, with physicians receiving $78 of it, hospitals $41, and dentists $33. The balance is about equally divided between medicines and miscellaneous expenses.

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WITH ANTIBIOTIC TYROTHRICIN FOR SENSITIVE SKIN

Candid Comments

[*Continued from page* 60]

waiting outside for nursing attention. I believe profoundly that it is through organization that we work most effectively, but the tail should never wag the dog. It could be that some nurses reject professional memberships because the programs do not reflect the yearnings within them. There is a big difference between medical lectures and research projects designed to improve *our* skills and knowledge, and getting down to brass tacks on patient and community nursing needs, and what it takes to meet them. Certainly I'm all for improving ourselves in every possible way, but the effort should be related to the larger, recognized objective of adequate nursing care.

We cannot generalize about our situation. As in medicine, where sharp contrasts exist between the surgeons described by Dr. Alvarez and the many dedicated men and women, we too have sharp contrasts. In all ranks we have an army of nurses who, I believe, have never lost the humility, simplicity and tranquility that enable them to gauge our challenges in terms of what we came for. But in this era of obeisance to science, others have let ambition— and in some cases, love of power—blind their eyes.

There never has been a period of more glorious challenge than now. Not only has our knowledge of man and his diseases vastly increased, and our facilities for his restoration multiplied, but nursing is reaching out

Best-known combination to break up congestion of colds— **steam and Vicks VapoRub!**

For croupy coughs, bronchial congestion and laryngitis, soothing steam medicated with VapoRub's volatile ingredients usually brings fast, dramatic relief. It moistens the dry, irritated membranes, helps loosen phlegm and restore normal breathing quickly.

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to give its help to mankind over the earth. We are entering an era that offers the greatest adventures of all time to people dedicated to helping others. Arnold Toynbee sums it briefly: "Our age will be remembered chiefly neither for its horrifying crimes nor astonishing inventions, but for its having been the first age since the dawn of civilization, some five or six thousand years ago, in which people dared to think it practicable to make the benefits of civilization available for the whole human race."

Wherever the "benefits of civilization" are made available, there we find nurses and nursing opportunities. Here at home are opportunities in our splendid military nursing services, in industry, schools, homes, hospitals, offices. Abroad are widening opportunities to bring the lessons of health and the blessings of skilled care to primitive peoples hungering for health after generations of hideous maiming and killing diseases. When I think of the magnificent adventures in human well-being opening for nurses in these lands, I break the "thou shalt not covet" Commandment. They bring to mind my own adventures in the early days of public health nursing when miracles unfolded before our eyes as people grasped the new lessons of health.

The challenges are still there—in abundance. The will to meet them is still aflame. May the Lord grant nurses the humility, simplicity, and tranquility to combine these two in wisdom.

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A Message of Hope

[*Continued from page* 69]

fully met the challenge of a similar cancerous condition. Among the types of cancer from which Club members have recovered are breast, bone, laryngeal, intestinal, stomach, kidney, urinary bladder, and uterine cancer. One member has had an eye enucleation. Two others have had brain tumors removed.

Members of the Club generally observe that what cancer does to a person is, like every other disaster, closely related to his own nobility of spirit. When material things no longer hold so great a meaning, a person can serve as a mirror to the vanity of others, thus tending to raise ethical standards. By some strange law of compensation, which they say healthy people cannot understand, Cured Cancer Club members find that no life is too short for some of this new happiness and enrichment.

An instructive, animated movie, "Stop Rheumatic Fever," showing how the disease can be prevented by treatment of "strep" infections, has been made available for health education uses through the cooperation of the U.S. Public Health Service and the American Heart Association. The film, a 16 mm. black-and-white short (running time: 12½ minutes), is suitable for showing before all groups interested in community health. Further information can be obtained from the local heart associations and the American Heart Association, 44 East 23 St., New York, N.Y.

News

[*Continued from page* 71]

for all those students who complete a year of preclinical study at Southern University. The new $325,000 school, scheduled for completion next September, will have a student capacity of fifty and facilities which include classrooms, library, sun deck, recreation lounge, and beauty parlor.

▶ OCCUPATIONAL Health Institute, an agency of the Industrial Medical Association, has created an advisory committee of industrial nurses. Named recently to serve on the committee were Mary Delehanty of the Equitable Life Assurance Society and former president of the American Association of Industrial Nurses, AAIN treasurer Margaret W. Lucal of the Ohio Rubber Company, AAIN first vice-president Gertrude A. Stewart of the International Business Machines Corporation, and AAIN president Sara P. Wagner of the Standard Oil Company of New Jersey.

▶ IN INDIANA, an educational program in psychiatric nursing, with credit toward a B.S. or M.S. degree, is being offered by the Department of Mental Health in collaboration with the University of Indiana. On-the-job training, tailored to meet the individual needs of the graduate nurse, is being given in ten of the state's psychiatric hospitals. Salaries, ranging from $190 to $260 a month, are based on three-fourths of a 40-hour

work week. Further information and application forms may be obtained from the Psychiatric Nursing Director, 1315 West Tenth Street, Indianapolis 7, Ind.

▶ APPLICATIONS for the 1956 Mary M. Roberts Fellowship in Journalism, an annual award sponsored by the American Journal of Nursing Company, are now being accepted, the company reports. Forms, eligibility requirements, and other details may be obtained from the sponsor's Roberts Fellowship Committee, 2 Park Avenue, New York 16, N. Y.

▶ OHIO'S new Nurse Practice Act, effective Jan. 1, provides for the establishment of (1) a governing board comprised of five R.N.'s and three L.P.N.'s to regulate nursing education and licensure, and (2) an advisory council which includes two hospital administrators, a member of the state medical association, a non-nurse member of the Ohio League for Nursing, a hospital trustee, a member of the Ohio Public Health Association, and a representative of the state's Department of Education. Among other things, the act requires annual renewal of licenses: for R.N.'s beginning Dec. 1, 1956, and for all L.P.N.'s starting June 1, 1958.

▶ SEVEN competitive scholarships for 1956-57, including two new awards for out-of-state students, have been announced by the Duke University School of Nursing, Durham, N. C., with Feb. 15 next as the dead-

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line date for applications. Six of the scholarships apply to the four-year B.S.-degree program, and one to the three-year R.N.-diploma course. Details and application forms may be obtained by writing to the school.

▶ A BUST of Clara Maass, America's nurse heroine who gave her life in the Army's yellow fever experiments at the turn of the century, was unveiled recently at the Lutheran School, Colegio Clara Maass, Havana, Cuba. A profile of the bust is reproduced on the 1955 Christmas seals of the Clara Maass Memorial Lutheran Hospital, Newark, N.J.

▶ A ONE-WEEK COURSE in industrial nursing, limited to fifty nurses, will be given at the New York University Post-Graduate Medical School beginning Nov. 14. Applications should be sent to the Dean, 550 First Avenue, New York 16, N. Y. Tuition: $40.

▶ GOLDEN JUBILEE of Sister Mary Aquinas, administrator of the 152-bed St. James Mercy Hospital, Hornell, N. Y., brought a flood of congratulations, including a telegram from President Eisenhower. Trained at the hospital, which she entered as a Sisters of Mercy novice in 1905, the nun is credited with the unique record of having helped to bring 5,000 babies into the world.

▶ NEWSLINGS: An iron lung, missing for two years from the Brackenridge Hospital in Austin, Tex., was finally traced to a distant hospital in the southern part of the state. Investigation revealed that it had been in and out of various hospitals in various communities, a result of its frequent use in transferring polio patients from town to town . . . Since leaving her New Zealand home six years ago, Nurse Louise Sutherland has pedalled a bicycle 20,000 miles through Europe, the Middle East, and India on a round-the-world tour. At last report, the 29-year-old nurse had reached British Columbia, with New York as her destination by early winter . . . Olga Erzighkeit, a Canton, Ohio, nurse-lecturer who has won two medals from the Freedom Foundation, is sponsoring a series of freedom essay contests in various local schools, offering as prizes the money she received for her lectures.

▶ MEETINGS: Annual convention of the National Society for Crippled Children and Adults takes place at the Palmer House, Chicago, Ill., Nov. 28-30 . . . The American Public Health Association holds its 83rd annual meeting in the Kansas City, Mo., Municipal Auditorium, Nov. 14-18.

▶ PUBLICATION headquarters of *The Catholic Nurse*, official journal of the National Council of Catholic Nurses, has been transferred from Boston to Washington, D. C., with Dorothy N Kelly, R.N., in charge as publication director. Archbishop Richard J. Cushing, widely known Boston prelate who has sponsored the magazine since its inception in 1952, continues as editor-in-chief.

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CONFIDENCE

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Color Code

[*Continued from page* 73]

more accurate physical inventories of laundry. Salem, like other hospitals, was accustomed to having its linen items counted by nurses when inventory time rolled around. Many of them looked upon this chore as an added burden—which, no doubt, it was. As a result, "rough estimates" rather than actual counts were frequently reported on the tally sheets. Thus, the physical inventory, an all-important yardstick in any system of laundry control, completely lost its significance.

To remedy the condition, the job of taking inventory was assigned to the laundry manager. With the aid of one assistant, he personally undertook the next physical count—and was able to complete it within nine working hours over a three-day period. (Inventory sheets prepared in advance helped to speed up the tabulation.) The result was a reliably accurate count, less confusion in the hospital's nine patient areas, a more contented nursing staff, and—most important of all—a dependable system of inventory control.

Subsequent comparison between dollar losses incurred before 1949 and since have given the hospital indisputable proof that the change-over has paid off. "But please don't think," says laundry manager Edwin T. Cullen, "this new system has solved *all* the linen problems at Salem Hospital. Any system is only as good as the people using it, and the human element is still the dominating factor.

A remarkable preventive now exists that could well make ammonia (common) diaper rash an almost *non-existent* infant disorder. Conclusive proof is at hand that Mennen Baby Magic Skin Care actually prevents diaper rash, and has effective healing powers as well.

In one series of tests, 85.5% of cases of ammonia diaper rash were completely cured, from a clinical standpoint. *There was only one recurrence while Baby Magic was being used!*

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Send for free copies of "Proper Usage of Mennen Baby Magic in the Hospital Care of the New Born". This booklet, prepared especially for doctors and nurses, includes the results of clinical studies. Write to The Mennen Company, Morristown, N. J.

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Physiologically acceptable Neo-Synephrine hydrochloride solution promptly constricts the engorged nasal capillaries which are responsible for nasal congestion in the common cold. When the nasal mucosa is reduced to its normal state, the nasal passages resume their proper patency, drainage is possible, and the patient can again breathe freely.
By its shrinking action on the nasal mucosa, Neo-Synephrine helps to keep the sinuses aerated and the openings to the eustachian tubes clear.
Neo-Synephrine within minutes produces decongestion that lasts for hours.
NEO-SYNEPHRINE®
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DOSAGE FORMS Solutions: 0.25% — 0.25% (aromatic) — 0.5% — 1% —
Emulsion 0.25% — Jelly 0.5%
Nasal Spray 0.5% (plastic, unbreakable squeeze bottle)
Nasal Spray Pediatric 0.25% (new introduction)
Contains Zephiran® Cl 0.02% (1:5000), antibacterial wetting agent and preservative for greater efficiency.
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ADMINISTRATORS: (a) New small gen'l hosp, completion Dec, pref available soon to engage staff, small town near wealthy agricultural area, MW. (b) Small hosp with expansion program 1956 outside U.S., delightful climate, $6000. RN11-1, Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

ANESTHETIST: Male or female to work part time as anesthetist and part time in some other capacity such as nurse or X-ray and lab technician. 65 bed hosp approved by ACS. Approx, 30 anesthesias per mo, about half for minor surgery. Contact Mrs. Mattie E. Curry, R.N., Administrator, The Hillsboro Hospital, Hillsboro, Ill. Tel. 270.

ANESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ANESTHETISTS: (a) Free lance or percentage, small agricultural town, Missouri. (b) Chief and Asst, 150 bed gen'l hosp, metropolitan area, $500, $450 respectively, MW. (c) Staff, 250 bed new gen'l hosp, resort area So: $400-475. (d) Ass'n 12 man group, own hosp. 200 beds, $550 mtce, So. (e) Staff, 70 bed gen'l hosp, North Lake Region, no OB. $435. (f) Chief and Ass't, 200 bed gen'l hosp college town, NW Mountain area, $6600-6000 respectively. (g) New 100 bed gen'l hosp, larger town Alaska, min. $500, RN11-2 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

ASS'T DIRECTOR OF NURSING IN CHARGE IN-SERVICE EDUCATION: To collaborate with ass't director in charge nursing service in reorganizing in-service educational program for all categories. B.S. Degree and satisfactory experience in teaching and/or supervision. Salary commensurate with education and experience. 500 bed voluntary hospital. Liberal personnel policies. Comfortable living quarters available at low cost. Easy accessibility to New York City and universities. Write to Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 8, N.J.

ASS'T INSTRUCTOR NURSING ARTS: Fully accredited School of Nursing with student body of 175. Position vacant January 1, 1956. Applicants will be accepted immediately. Write to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio

CALIFORNIA: Wide choice of locations for nurses in California's progressive state hospital system. Professional graduate nurses, no experience, $310-$358. One year psychiatric experience, $325-$376. Surgical nurses, $325-$376. Also many opportunities for nurses having additional psychiatric and supervising experience to start at higher salaries. All must be eligible for California registration. Write for descriptive literature on hospitals and information on temporary license pending registration. State Personnel Board, 801 Capitol Ave., Sacramento 14, Calif.

CLEVELAND OHIO JOB OPPORTUNITIES FOR REGISTERED NURSES: For 398 bed non-sectarian general hospital with school of nursing. Excellent opportunity for study at nearby Western Reserve University. Liberal personnel policies. We will assist you in finding living accommodations. For detailed information write to Helen Christian, R.N., Dept. of Nursing, Mount Sinai Hospital, 1800 E. 105th St., Cleveland 6, Ohio

CLINICAL INSTRUCTOR, SURGICAL NURSING: Fully accredited School of Nursing with student body of 175. Position vacant January 1, 1956. Applicants will be accepted immediately. Write to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio

DENVER COLORADO JOB OPPORTUNITIES: Staff nurses for 417 bed general hospital with school of nursing. Full or part time. Choice of working 5 or 5½ day week. Going salary for Rocky Mountain Region, bonus for evening and night duty. Paid sick leave, vacations and holidays, Social Security benefits. Some housing available or we will assist you in finding living accommodations. Excellent opportunity for study at Denver University. Denver's climate is unsurpassed the year around. Opportunities for sports and entertainment are many. If interested wire collect for additional information or write Director of Nursing Service, St. Luke's Hospital, 601 East 19th Ave., Denver 3, Colo.

DIRECTORS OF NURSING: (a) 450 bed gen'l, unusual oppor. Univ aff, btfl So Univ town, $6000-7000. (b) Nursing Service, new 400 bed gen'l hosp, ideal Florida location. (c) Leading Children's Hosp, interesting city, 80 affiliating students, $6000 up, E. (d) Gen'l 165 bed hosp, 75 students, college town, Mass., $6500. (e) 2000 bed mental, metropolitan area, MW, $6600 (f) New 550 bed hosp, specializing pulmonary diseases, open Dec. attract SW location, RN11-3 Burneice Larson, Medical Bureau, Palmolive Bldg., Chicago, Ill.

FACULTY POSTS: (a) Asst Prof—Med Surg for small newly organized Univ Faculty, $5500, MW. (b) Science Inst. 450 bed hosp, has Asst, NYC area, (c) Nursing Instr, renowned American owned company, outside U.S. (d) OR, OB, Ped Instructors, 400 bed modern gen'l hosp, accredited school of 170, interesting city outside US, $5400. (e) Nursing Arts and Clinical Instructors, small well known No Calif college, $4500. (f) Asst Profs Med-Surg and Fundamentals of Nursing, btfl Univ NW Mountain area, RN 11-4, Burneice Larson. Medical Bureau, Palmolive Bldg., Chicago, Ill.

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tor of Nursing, State Tuberculosis Hospital, Orlando, Tampa, Lantana or Tallahassee, Fla.

GENERAL DUTY: 40 hr wk, 84 bed hospital, finest equipment, very liberal personnel policies and pleasant working environment. Must be willing to rotate shifts. Salary range $277 to $360 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: For 76 bed general hospital in university town. Prevailing salaries paid. Full maintenance available. Redlands Community Hospital, Redlands, Calif.

GENERAL DUTY NURSES: 50 bed hospital approved by JCAH located in mountainous portion Colorado college town. Salary $275, 40 hr wk, sick leave, vacation bonus. Contact Superintendent, Community Hospital, Alamosa, Colo.

GENERAL DUTY NURSES: $250-$305. 165 bed approved general hospital. 2 and 3 week paid vacation. 12 days paid sick leave, 8 paid holidays. Annual raises. Board and room at nominal cost in new modern nurses' home attached to hospital. Vacancies all shifts. Apply Director of Nurses, Memorial Hospital, Cheyenne, Wyo.

GENERAL DUTY NURSES: 100 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies, 40 hr. wk. Starting salary $237.50 with a charge of $22.50 for full maintenance. Additional $10 per mo. for evening and night duty with regular increases. Surgical nurses starting salary $247.50 plus $5 per call after 5 p.m. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES: 38 bed hospital. Prevailing salaries paid. $10 per mo. for evening and night shift, 40 hr wk. San Gorgonio Pass Memorial Hospital, Banning, Calif.

GENERAL DUTY NURSES: Opportunity to learn nursing team leadership in 400 bed general hospital, salary $290 to $310 per mo for a 40 hr wk, $30 additional for evening and night duty. Uniforms are laundered free, liberal personnel policies, comfortable residence at moderate cost. Good transportation to colleges and universities and shopping centers. Apply Director, Nursing Service, Mount Sinai Hospital, 2750 West 15th St., Chicago 8, Ill.

GENERAL DUTY NURSES: New 50 bed general hospital thriving village Catskill Mountains. Gross salary $260 mo, full maintenance available $10.50 week, other benefits. Apply Supt. Nurses, Margaretville Hospital, Margaretville, N.Y. Telephone 0501.

GENERAL DUTY NURSES: For new 60 bed general hospital. Immediate openings. $250 to $270 depending upon experience and qualifications. Periodic increases and opportunity for advancement. Sick leave, 4 holidays, 2 weeks vacation. Blue Cross, Blue Shield optional. Rotating shifts. $10 differential for evenings and nights. Contact: Barbara A. Dawson, Supt. of Nurses, Cheyenne County Memorial Hospital, Sidney, Nebr.

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GENERAL STAFF NURSES: 270 bed general hospital and 72 bed maternity hospital. Starting salary $305, $5 per month tenure increase for each 6 months of service to a maximum of $335. $25 additional for afternoon and night shift, $25 additional for surgery. Liberal paid annual vacation, 7 paid holidays, 8 hr. day, 40 hr. week. Social Security and employer-paid help and life insurance program. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: Preferably with psychiatric training and experience for 1600 bed State Hospital. Good working conditions. Permanent positions. Salary $276 to $415 starting, depending on qualifications. Can attain $481 monthly in supervisory capacity. Apply Personnel Director, Osawatomie State Hospital, Osawatomie, Kans.

GRADUATE NURSES: Needed for the new modern 1238 bed Veterans Administration Hospital now being opened in the heart of New York City. Liberal personnel policies include 40 hr week, 30 days vacation, 15 days sick leave, 8 holidays, uniforms laundered free. Rotating shifts. Basic starting salary $4025 per year with yearly increases to $4885, higher salaries based upon experience and educational qualifications. Blue Cross Plan and Group Life Insurance available. Local Universities accessible. Cultural and recreational advantages readily available throughout city. Apply to Chief, Nursing Service, Veterans Administration Hospital, 408 First Ave., New York 10, N.Y. Telephone Murray Hill 6-7500, Ext. 256.

GRADUATE NURSES: Positions for those who either have or are willing to obtain Colorado registry. Floor duty, rotating shifts, uniform laundry and meals furnished, 2 weeks paid vacation and 7 days sick leave per year. 35 bed hospital in a growing community. Southwest Memorial Hospital, Cortez, Colo.

GRADUATE NURSES & ASS'T HOUSE SUPERVISOR: 3-11 shift. Openings for general duty on all shifts, no rotating, delivery room 11-7 and operating room. Good salary with automatic pay increases every 6 mos for 2 yrs. 5 day week, 2 wks vacation, 12 days sick leave annually and 6 paid holidays. $15 differential for 3-11, 11-7 and OR with extra day pay for call duty in OR when called. 140 bed general hospital, no school of nursing. Living quarters available at nominal cost. Write Director of Nurses, Christian Hospital, 4411 N. Newstead, St. Louis 15, Mo.

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INSTRUCTOR-MEDICAL & SURGICAL NURSING: Degree required, immediate opening, salary dependent upon preparation and experience, admit one class a year. 95 students in the school. Excellent personnel policies, including 40 hr wk, all cash salary, Social Security and retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton, N.J.

INSTRUCTORS: 1 Medical Clinical Instructor and 1 Ass't Nursing Arts Instructor for 502 bed hospital in Philadelphia area. Salary based on qualifications of applicant. Automatic salary increases. 40 hr wk, 28 days vacation, 14 days sick leave. Blue Cross plan available. Teaching duties only. Opportunity to pursue additional University courses. Apply to Director of the School of Nursing, Cooper Hospital, Camden, N.J.

NEW YORK CITY HEALTH DEPT: Has vacancies in two entrance level positions. Registered Nurse, Salary $3500-$3980. Opportunity for registered nurses seeking public health qualifications. Immediate appointment. 37 hr wk, liberal personnel policies. Applicants must be able to matriculate for public health nursing courses at university. Qualified Public Health Nurse, Salary $4000. Immediate appointment on a provisional basis. Permanent appointment with increases up to $5080. 37 hr wk. liberal vacation and personnel policies, pension rights, in service training, promotional opportunities. Generalized service including maternal and child care, school health and communicable disease control. Applicants (except New York State Veterans) must not have reached 36th birthday. Write or call the New York City Dept. of Health, 125 Worth St., New York 13, N.Y.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General duty and operating room, 125 beds, Suburban Hospital, Bethesda, Md.

NURSES: 1 Asst. Dir. N.S., salary $361-426, 1 Head Nurse for Surgery, $293-361, 1 Supervisor Coordinate Surgery C.S.R. and Emergency Room, $325-401. Registered Staff Nurses for days, P.M. & night services, $278-325 with $10 for p.m., nights. $10 for TB, Isolation, Pediatrics, N.P. & Surgery. 15 paid working days vacation after 1 year. 15 paid working days sick time accruable to 90 days, 11 paid holidays, 40 hr wk. Write Director Nursing Service, Monterey County Hospital, P.O. Box 1611, Salinas, Calif.

NURSES: Graduate, Registered, Staff. In-service education, liberal personnel policies, rotating shifts, starting salary $300. Apply Nursing Supervisor (Mrs. Lippincott), Polio Center, 1801 Buffalo Drive, Houston 3, Tex. CA 4-7875.

NURSES: Immediate openings for operating room supervisor and staff nurses, all shifts. Modern 75 bed air-conditioned hospital overlooking beautiful Lake Monroe in Central

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NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES-FLORIDA: Take advantage of Florida's sunshine and pleasant living. Jacksonville's rapid growth has created a need for more hospital beds. Registered nurses are needed for surgical, obstetrical and general duty. Modern 375 bed general hospital on the beautiful St. Johns River. Basic salary $221 per mo with increments for evening and night duty and for surgical nursing. 40 hr wk. Apply Director of Nursing Services, St. Vincent's Hospital, Jacksonville, Fla.

NURSES—GENERAL DUTY AND SURGICAL: For 250 bed hospital in residential suburb of Chicago. 40 hr. wk. Cash salary $240 for night duty, $235 evening duty and $225 day duty. $10 increase after 60 days and at regular intervals. $15 differential for surgical nurses. Full maintenance in addition to salary includes single room in new nurses residence plus meals and laundry. Low rental apartments for married nurses. 2 to 4 weeks vacation, 6 holidays. Sick time policy. Free life insurance. Blue Cross hospitalization. Leave of absence with full salary for post graduate study granted to qualified nurses. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

NURSES, R.N.: and Floor Duty, 3-11, 11-7, 5 days a week. New general hospital. Good salary and working conditions. Apply M. K. Moloney, R.N., Liberty Maimonides Hospital, Liberty, N.Y. 'Phone Liberty 2300.

NURSING ARTS INSTRUCTOR: In school of nursing with capacity for 100 students attached to an expanding hospital. Diploma program with college affiliation for biological and social sciences. B.S. Degree in nursing preferred or commensurate experience and working toward a degree. Salary dependent on qualifications. Position open January 1, 1956. Apply at once to Director, Dept. of Nursing, Research Hospital, Kansas City, Mo.

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OBSTETRICAL SUPERVISOR: For 49 bed, 49 bassinet service in accredited hospital with fully approved school of nursing. Opportunity for experienced head nurse to combine supervisory responsibility with advanced study at Western Reserve University. Liberal personnel policies. Apply to Moses Baskin, Ass't Director in Charge of Patient Care, Mount Sinai Hospital, 1800 E. 105th St., Cleveland 6, Ohio

OLDER NURSE OR OFFICE WORKER: For Record Department. Address Frontier Nursing Service, Wendover, Leslie County, Ky.

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OPERATING ROOM NURSES: Immediate appointments at 903 bed medical center with oopportunity for advanced experience in general and special surgery. Positions provide many personal benefits including health services, 30 days vacation with pay and low cost housing available. Salaries for head nurses range from $320 to $360 per mo for 40 hr wk. Salary range $305 to $340 per mo for staff nurses. Overtime paid for at rate of $2 per hr. The Medical Center is centrally located near the Chicago "loop". 6 universities readily accessible. Many other advantages in America's No. 2 city. For further information write: Director of Nursing Service, Michael Reese Hospital, Medical Center, Chicago 16, Ill.

OPERATING ROOM NURSES: Immediate openings. 166 bed approved general hospital. $280 to start, annual $10 raise for 3 years. Additional pay for call. 2 and 3 wks vacation with pay and 8 paid holidays yearly. Paid sick leave. New operating room suite. New modern well-equipped nurses' home attached to hospital. Very nominal cost. Contact Director of Nursing Service, Memorial Hospital, Cheyenne, Wyo.

OPERATING ROOM & DELIVERY ROOM NURSES: Modern 115 bed hospital, 125 mi. from N.Y.C. All graduate staff. Good personnel policies. 40 hr wk, straight shift, every other week-end. Write Director of Nursing, Mount Sinai Hospital, Hartford, Conn.

OPERATING ROOM & 3-11 NURSES: For college hospital. Salary dependent upon experience. Liberal personnel policies. One month paid vacation plus 2 wks accumulated sick leave after 1 yr of service. Double time for holidays. Meals and laundry furnished. Apply Superintendent, Allen Hospital, Oberlin College, Oberlin, Ohio

OPERATING ROOM NURSES: New 50 bed general hospital thriving village Catskill Mountains. Gross starting salary $270 mo, full maintenance available $10.50 week, other benefits. Apply Supt. Nurses, Margaretville Hospital, Margaretville, N.Y., Telephone 0501

OPERATING ROOM NURSES: Immediate appointments. 511 bed newly enlarged and finely equipped hospital. 10 operating rooms now completed. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living cost reasonable. Within pleasant driving distance advantages of metropolitan Cleveland, Columbus and Pittsburgh. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

OR SUPERVISOR & GENERAL DUTY NURSES: For 43 bed general hospital located midway between the Gulf of Mexico and Atlantic Ocean in farming community of 5,500 inhabitants. Good salary, complete maintenance and paid vacation. Apply to Catherine M. Hurst, R.N., Directress of Nurses, Suwannee County Hospital, Live Oak, Fla.

OVERSEAS JOBS: Interested in overseas nursing? Many companies need nurses in their dispensaries and company-owned hospitals. Send $1 for list which includes a large number of companies operating in foreign countries. Satisfaction guaranteed. Len Rathe, Box 173, New Orleans 3, La.

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PUBLIC HEALTH: (a) Outpatient-Emergency—650 bed new gen'l inst, exc oppor., college town 75,000 So. (b) Exec Dir. VNA S. W., $140,000 budget 1956, $6000-$7500. (c) PH Supervisors, and Staff, outside USA. (d) PH College Faculty Nurse, Ohio, RN11-6, Burneice Larson Medical Bureau, Palmolive Bldg., Chicago, Ill.

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REGISTERED NURSES: 180 bed hospital for chest diseases, including operable heart and cancer. $250 per mo to start with full maintenance. Vacation, sick leave. Deborah Sanatorium, Browns Mills, N.J.

REGISTERED NURSES: Sunny Los Angeles, Southern California's most glamorous city has a new modern 250 bed hospital located near the beautiful Beverly Hills area, which offers a new kind of opportunity for nurses interested in good patient care and learning about latest techniques. In a relaxed and beautiful atmosphere, work with friendly people, enjoy time off at nearby beaches and resorts. Housing facilities in the neighborhood. Starting salary $300 per mo with semi-annual increases for three years, 8 paid holidays, sick leave, Social Security, group insurance and unemployment compensation. Generous vacation. Opportunities for advancement. In-service program for R.N. and auxiliary workers. Apply Director of Nurses, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, Calif.

REGISTERED NURSES: For charge and staff nursing in a modern 140 bed fully accredited general (private) hospital. Evening and night duty differential $10. Straight hours. No rotation of shifts. 40 hr wk, living quarters available in heart of the theatrical and shopping district. Also pos. open for OR suture nurses, any shift. Apply Director of Nurses, Medical Arts Center Hospital, 57 W. 57th St., New York 19, N.Y.

REGISTERED NURSES: For expanding services to 215 beds. Functionally modern hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter resort areas. Staff and charge positions open. Starting salaries are dependent upon educational background and experience with a minimum of $260 to $300 per month. Monthly differential of $20 for afternoon duty and $15 for night duty. 40 hr. wk. Excellent personnel policies. Stimulating and progressive environment. Nursing department has collegiate education affiliation. Accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

REGISTERED NURSES: Immediate openings in 250 bed general hospital on day and evening shifts. Minimum salary $285 with $10 differential for evening OB and OR. Holidays, vacations, prepaid hospitalization and insurance. Apply to Director of Nurses, Mercy Hospital, Sacramento, Calif.

REGISTERED NURSES: In progressive 250 bed fully approved hospital located in beautiful, exciting western city with ideal climate, mild winters. 5 day week, 40 hrs., starting salary $265 with automatic increase every 6

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mos., of $100 per year, or $8.33 per mo. up to three years, $10 per mo. differential paid to those working afternoon and night shifts. Minimum wage scale for surgery nurses is $275. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

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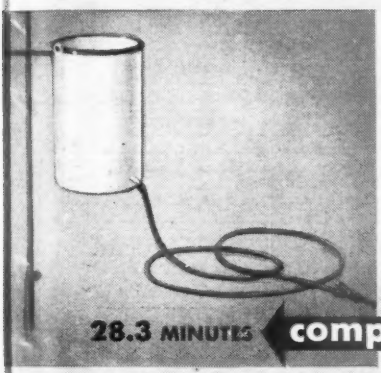

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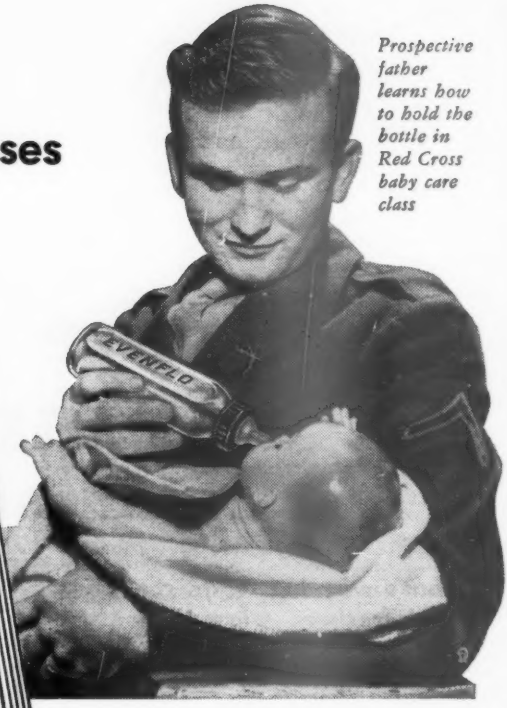

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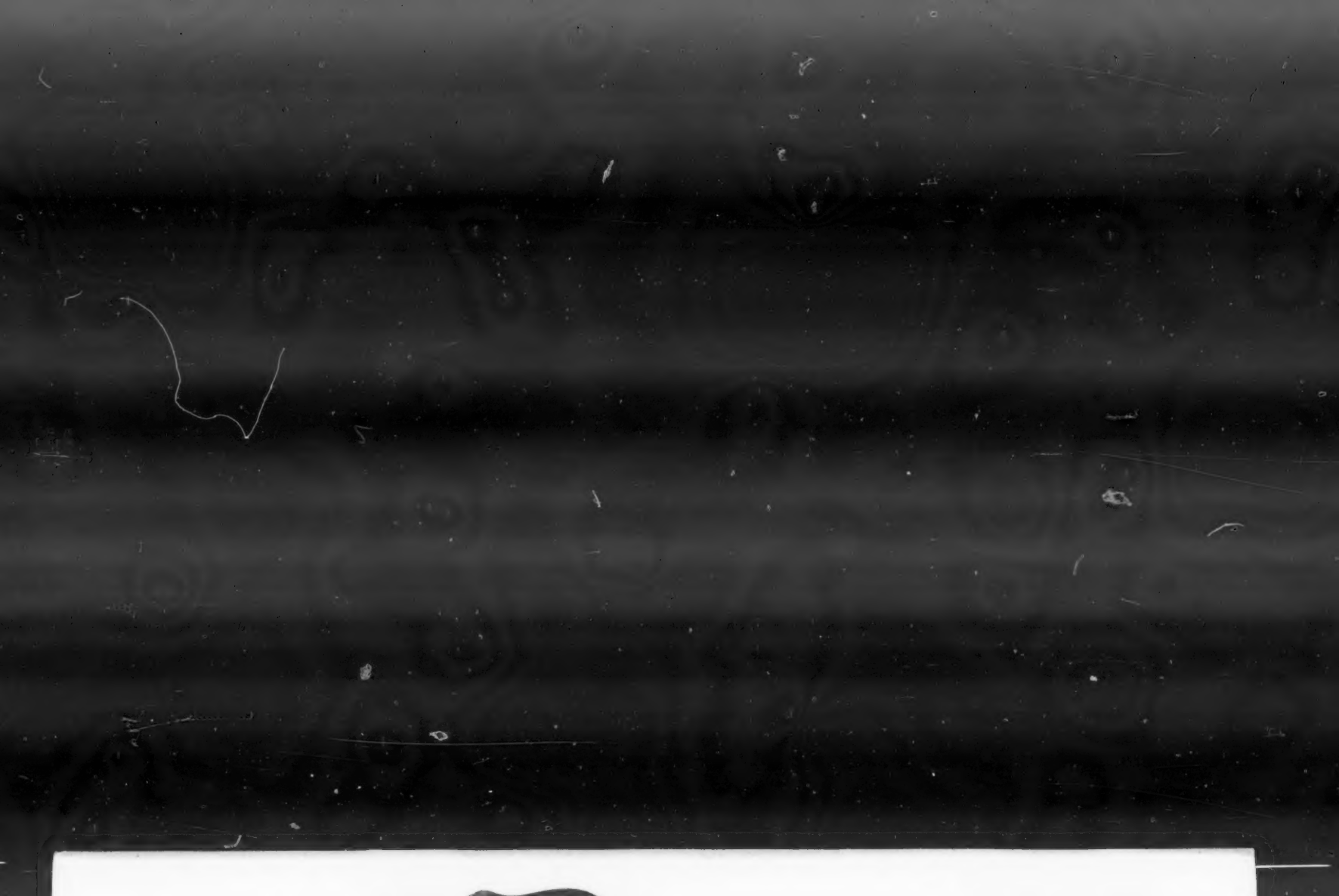

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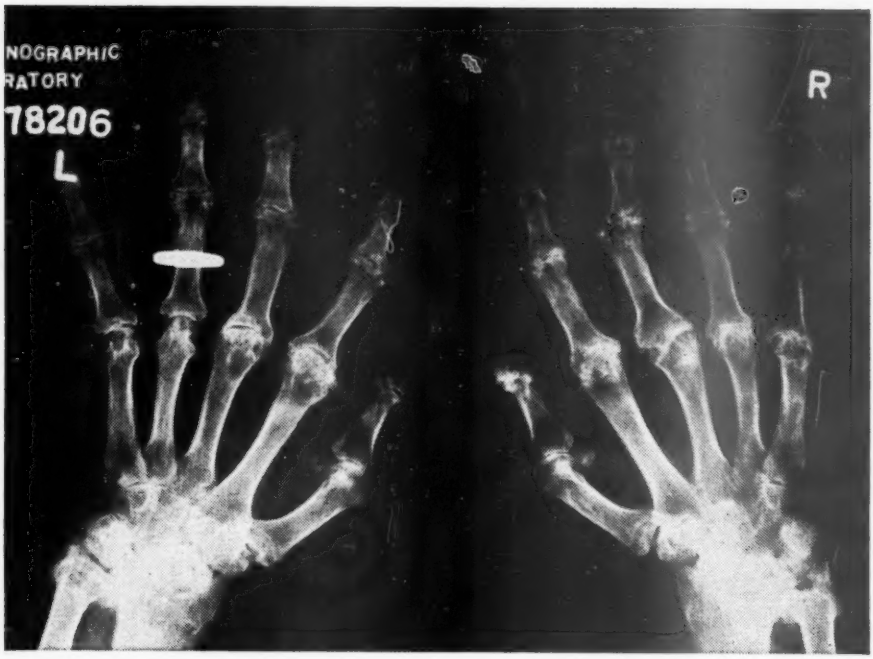

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